Form Approved OMB Control No.0920-0134

Exp X/XX/XXXX



Air Travel Illness or Death Investigation Form

U.S. Centers for Disease Control and Prevention

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| **Section 1. Quarantine station notification** | | | | | | | | | | | | | | | |
| QARS Unique ID #: | | | CDC User ID : | | | | Port of Entry: | | | | | | State: | | |
| Person notifying CDC: | | | | | | | Phone: | | | | Email: | | | | |
| Agency notifying CDC: | | | | | Date of initial notification to CDC: | | | / /  mm dd yyyy | | | Time of initial notification to CDC (24 hrs): | | | :  hh : mm | |
| Type of notification: □ Illness □ Death □ Traveler Follow up | | | | | | | When was the Quarantine Station notified?:   * Before any travel was initiated * During travel   + Prior to boarding conveyance   + While traveler was on a conveyance   + After disembarking conveyance * After travel completed (reached final destination for that leg of trip) * Unknown | | | | | | | | |
| Type of traveler: □ Passenger □ Crew | | | | | | |
| Where was the traveler when the QS was notified?:   * In U.S. jurisdiction / Inbound * In foreign jurisdiction / Outbound * Unknown | | | | | | |
| **NOTE**: If ill/deceased person also traveled via □ Land and/or □ Maritime conveyances, please fill out the appropriate form and attach | | | | | | | | | | | | | | | |
| **Section 2. Pertinent medical history of ill or deceased person** | | | | | | | | | | | | | | | |
| Relevant history: present illness, other medical problems, vaccinations, overseas physician diagnosis, etc.: | | | | | | | | | | | | | | | |
| Traveler has taken:   * Antibiotic/antiviral/antiparasitic(s) in the **past week**; list with date(s) started: * Fever-reducing medications (e.g. acetaminophen, ibuprofen) in the **past 12 hrs**; list with time of last dose: * Other medications (related to current symptoms/illness); list with date(s) started: | | | | | | | | | | | | | | | |
| **Relevant Exposures in the Past 3 Weeks:** | | | | | | | | | | | | | | | |
|  | Village/City/State | Province/Country | | Arrival Date | | Exposure to ill persons? | | | Exposure to animals? | | | Other exposures (chemical, drug ingestion, etc)? | | | |
|  |  |  | |  | | * No   □Yes, | | | * No   □Yes, | | | * No   □Yes, | | | |
| Relevant Vaccinations  Traveler up to date on relevant vaccinations □ Yes □ No □ Vaccinated with NON-WHO or NON-FDA approved vaccine □ Unknown  Vaccine Type: ; Dose 1 date: / / Manufacturer ; Dose 2 Date: / / Manufacturer ; Dose 3 date: / / Manufacturer Information Source: □ Vaccine card □ Medical Record □ Vaccine Digital Passport □ IATA Travel Pass □ State Records □ Traveler Recollection □ Other Specify: | | | | | | | | | | | | | | | |
|  | Relevant Testing | | | | | | | | | | | | | |  |
|  | Disease tested: Testing Method: Specimen Source: Specimen Collection Date: Date Lab Test Available: Interpretations of Results.  Comments: | | | | | | | | | | | | | |  |
| **Signs, Symptoms, and Conditions (check all that apply):** | | | | | | | | | | | | | | | |
| * FEVER (≥100°F or ≥38°C) **OR**   feeling feverish/having chills in past 72 hrs Onset date:  **/ /** Current temperature: 0 F/C   * Rash   Onset date:  **/ /** | | | | | * Difficulty breathing/shortness of breath Onset date: / / * Swollen glands   Onset date: / / Location: □ Head/neck □ Armpit □ Groin | | | | | * Decreased consciousness   Onset date: / /   * Recent onset of focal weakness and/or paralysis   Onset date: / / | | | | | |
| Appearance:   * Maculopapular □ Vesicular/Pustular * Purpuric/Petechial □ Scabbed □ Other * Conjunctivitis/eye redness   Onset date: / /   * Coryza/runny nose | | | | | * Vomiting   Onset date: / / Number of times in past 24 hrs?   * Diarrhea   Onset date: / / Number of times in past 24 hrs?: | | | | | * Unusual bleeding   Onset date: / /   * Obviously unwell * Injury | | | | | |
| Onset date: / /   * Persistent cough | | | | | * Jaundice   Onset date: / / | | | | | * Chronic condition * Asymptomatic | | |  |  |  |

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| Onset date: / /   * With blood □ Without blood | | | | | | | | | * Headache   Onset date: / /   * Loss of Sense of Taste or Smell Onset date: / / | | | | | | | | | | * Other: | | | | |
| * Sore throat   Onset date: / / | | | | | | | | |  | | | | | | | | | |  | | | | |
| **Deceased Persons:** | |  |  | Date of Death: | | | / /  mm dd yyyy | | | | | | | |  |  | Time of death (24 hours): | | |  | :  hh : mm | |
| **Presumptive Diagnosis or Cause of Death:** | | | | | | | | | | | | | | | | | | | | | | |
| Does anyone else on the plane have similar illness?: **□** No **□** Yes\* **□** Unknown  \*If yes, please fill in a new form for each person in the cluster | | | | | | | | | | | | | | | | | | | | | | |
| **Response or Info Only:**   * Requires DGMQ Response & Follow-up **(Proceed to next section)** * Information Report Only / No Follow-up needed **(STOP HERE)** | | | | | | | | | | | | | | | | | | | | | | |
| **Section 3. General information about the ill or deceased person or traveler who may need follow up** | | | | | | | | | | | | | | | | | | | | | | |
| Last/paternal name: | | | | | | | | | | | | First/given name: | | | | | | | | | | |
| Middle name: | | | | | Maternal name (if applicable): | | | | | | | | | | | Other names used (e.g., former name, alias): | | | | | | |
| Gender: | * Male * Female |  |  | Date of birth: |  | / /  mm dd yyyy | | | | | Age (if date of birth unknown): | | | | | | | | □ Days □ Weeks  □ Months □ Years | | | |
| Country of birth: | | | Passport country/citizenship: | | | | | | Type of ID: | | | | | | ID document #: | | | | | Alien #: | | |
| **For deceased persons, go to Section 5. Otherwise, continue below.** | | | | | | | | | | | | | | | | | | | | | | |
| Home address: | | | | | | City: | | | | | | | | | State/province: | | | | | Zip/postal code: | | |
| Country of residence: | | | | | | Home phone: | | | | | | | | | If visiting, total duration of  U.S. stay: | | | | | □ Days □ Months  □ Weeks □ Years | | |
| Contact in U.S. - Address/hotel:   * Same as home address above | | | | | | | | | | | | | | | E-mail: | | | | | | | |
| Contact in U.S. - City: | | | | | | Contact in U.S. - State/territory: | | | | | | | | | Contact phone in U.S.: | | | | |  |  |  |
| * Cell # of days reachable at contact phone: | | | | | | | |
| Emergency contact name: | | | | | | Emergency contact relationship: | | | | | | | | | Emergency contact phone: | | | | | | | |
| **Section 4. Flight information** | | | | | | | | | | | | | | | | | | | | | | |
| Type\* | Domestic or Int’l? | Airline | | | | | Flight # | | | Departure Airport Code | | | | Departure Date | | | Arrival Airport Code | | Arrival Date | | Seat # | Flight Duration |
| **CURRENT FLIGHT:** | | | | | | | | | | | | | | | | | | | | | | |
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| **PREVIOUS AND/OR UPCOMING FLIGHTS:** | | | | | | | | | | | | | | | | | | | | | | |
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| \***C/FB** = Commercial, foreign-based carrier **C/US** = Commercial, U.S.-based carrier **P** = Private **CH** = Charter **CG** = Cargo MD = Medevac RP = Repatriation **O** = Other | | | | | | | | | | | | | | | | | | | | | | |
| **Section 5: Public Health Entry Requirements** | | | | | | | | | | | | | | | | | | | | | | |
| **Entry Requirement:**  Did traveler meet the US Global Public Health Entry Requirements: □ Yes □ No □ N/A Please specify: | | | | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | | | | |
| **Section 6: Disposition of traveler/ill/deceased person** | | | | | | | | | | | | | | | | | | | | | | |
| **Ill person was (check all that apply):** | | | | | | | | | | | | | **Deceased Person:** | | | | | | | | | |
| * Released to continue travel * Advised to seek medical care * EMS responded * Recommended to not travel * Transported to hospital (□ MOA activated): * Transported to non-hospital location: * Detained by law enforcement, location: | | | | | | | | | | | | | Body released to medical examiner?: □ Yes □ No Medical examiner telephone:  City/State/Country: | | | | | | | | | |

* Denied entry by law enforcement
* Information transmitted to state and/or local health departments
* Other:

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data

needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-0134