



Air Travel Illness or Death Investigation Form U.S. Centers for Disease Control and Prevention

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: / /		Time of initial notification to CDC (24 :)		
Type of notification: <input type="checkbox"/> Illness <input type="checkbox"/> Death <input type="checkbox"/> Traveler Follow up		When was the Quarantine Station notified?:			
Type of traveler: <input type="checkbox"/> Passenger <input type="checkbox"/> Crew		<input type="checkbox"/> Before any travel was initiated <input type="checkbox"/> During travel			
Where was the traveler when the QS was notified?:		<input type="checkbox"/> Prior to boarding conveyance <input type="checkbox"/> While traveler was on a conveyance <input type="checkbox"/> After disembarking conveyance <input type="checkbox"/> After travel completed (reached final destination for that leg of trip) <input type="checkbox"/> Unknown			
<input type="checkbox"/> In U.S. jurisdiction / Inbound <input type="checkbox"/> In foreign jurisdiction / Outbound <input type="checkbox"/> Unknown					
NOTE: If ill/deceased person also traveled via <input type="checkbox"/> Land and/or <input type="checkbox"/> 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:					
<input type="checkbox"/> Antibiotic/antiviral/antiparasitic(s) in the past week ; list with date(s) started: _____ <input type="checkbox"/> Fever-reducing medications (e.g. acetaminophen, ibuprofen) in the past 12 hrs ; list with time of last dose: _____ <input type="checkbox"/> 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)?
			<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____
Relevant Vaccinations					
Traveler up to date on relevant vaccinations <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccinated with NON-WHO or NON-FDA approved vaccine <input type="checkbox"/> Unknown					
Vaccine Type: _____; Dose 1 date: ___/___/___ Manufacturer _____; Dose 2 Date: ___/___/___ Manufacturer _____; Dose 3 date: ___/___/___ Manufacturer _____ Information					
Source: <input type="checkbox"/> Vaccine card <input type="checkbox"/> Medical Record <input type="checkbox"/> Vaccine Digital Passport <input type="checkbox"/> IATA Travel Pass <input type="checkbox"/> State Records <input type="checkbox"/> Traveler Recollection <input type="checkbox"/> 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):					
<input type="checkbox"/> FEVER ($\geq 100^{\circ}\text{F}$ or $\geq 38^{\circ}\text{C}$) OR feeling feverish/having chills in past 72 hrs Onset date: ___/___/___ Current temperature: _____ ^o F/C <input type="checkbox"/> Rash Onset date: ___/___/___ Appearance: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Vesicular/Pustular <input type="checkbox"/> Purpuric/Petechial <input type="checkbox"/> Scabbed <input type="checkbox"/> Other <input type="checkbox"/> Conjunctivitis/eye redness Onset date: ___/___/___	<input type="checkbox"/> Difficulty breathing/shortness of breath Onset date: ___/___/___ <input type="checkbox"/> Swollen glands Onset date: ___/___/___ Location: <input type="checkbox"/> Head/neck <input type="checkbox"/> Armpit <input type="checkbox"/> Groin <input type="checkbox"/> Vomiting Onset date: ___/___/___ Number of times in past 24 hrs? _____ <input type="checkbox"/> Diarrhea Onset date: ___/___/___ Number of times in past 24 hrs?: _____	<input type="checkbox"/> Decreased consciousness Onset date: ___/___/___ <input type="checkbox"/> Recent onset of focal weakness and/or paralysis Onset date: ___/___/___ <input type="checkbox"/> Unusual bleeding Onset date: ___/___/___ <input type="checkbox"/> Obviously unwell <input type="checkbox"/> Injury			

Coryza/runny nose

Onset date: ____ / ____ / ____

Persistent cough

Jaundice

Onset date: ____ / ____ / ____

Chronic condition

Asymptomatic

Onset date: ____/____/____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood <input type="checkbox"/> Sore throat Onset date: ____/____/____	<input type="checkbox"/> Headache Onset date: ____/____/____ <input type="checkbox"/> Loss of Sense of Taste or Smell Onset date: ____/____/____	<input type="checkbox"/> Other: _____
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Deceased Persons:	Date of Death: ____/____/____ <small>mm dd yyyy</small>	Time of death (24 hours): ____:____ <small>hh : mm</small>
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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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth: ____/____/____ <small>mm dd yyyy</small>	Age (if date of birth unknown):	<input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> 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:	<input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Weeks <input type="checkbox"/> Years
Contact in U.S. - Address/hotel: <input type="checkbox"/> Same as home address above		E-mail:	
Contact in U.S. - City:	Contact in U.S. - State/territory:	Contact phone in U.S.: <input type="checkbox"/> 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:									
PREVIOUS AND/OR UPCOMING FLIGHTS:									

*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:
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- 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