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

Form Approved
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CDC Quarantine and Migration Health

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

Type of traveler: □ Crew □ Passenger □ N/A

Where was the traveler when the QS was notified?:
- □ In U.S. jurisdiction
- □ In foreign jurisdiction
- □ Unknown

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
  - □ While at the port as a pedestrian or in vehicle
- □ After travel completed (reached final destination for that leg of trip)
- □ Unknown

NOTE: If ill/deceased person also traveled via □ Air 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, 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:

Countries visited in the past 3 weeks:	State/city/village	Arrival date	Exposure to ill persons?	Exposure to animals?	Other exposures (chemical, drug ingestion, etc)?
			□ No □Yes,	□ No □Yes,	□ No □Yes,
			□ No □Yes,	□ No □Yes,	□ No □Yes,
			□ 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:

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:___/___/___
Appearance:
□ Maculopapular □ Vesicular/Pustular
□ Purpuric/Petechial □ Scabbed □ Other

□ Conjunctivitis/eye redness
Onset date:___/___/___

□ Coryza/runny nose
Onset date:___/___/___

□ Sore throat
Onset date:___/___/___

□ Difficulty breathing/shortness of breath
Onset date:___/___/___

□ Swollen glands
Onset date:___/___/___ Location:
□ Head/neck □ Armpit □ Groin

□ Vomiting
Onset date:___/___/___
Number of times in past 24 hrs? ___

□ Diarrhea
Onset date:___/___/___
Number of times in past 24 hrs?: ___

□ Jaundice
Onset date:___/___/___

□ Neck stiffness
Onset date:___/___/___

□ Decreased consciousness
Onset date:___/___/___

□ Recent onset of focal weakness and/or Paralysis
Onset date:___/___/___

□ Unusual bleeding
Onset date:___/___/___

□ Obviously unwell

□ Injury

□ Chronic condition

□ Persistent cough Onset date:____/____/____ □ With blood □ Without blood	□ Headache Onset date:____/____/____ □ Loss of Sense of Taste or Smell Onset date: / /	□ Asymptomatic □ Other: _____

Deceased Persons:	Date of Death: ____/____/____ (mm dd yyyy)	Time of death (24 hours)	____: (hh : mm)

Presumptive Diagnosis or Cause of Death:

If traveling by conveyance, does anyone else have similar illness?: □ No □ Yes □ Unknown (If yes, please fill in a new form for each person in the cluster.)

Response or Report:
□ 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

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:	Frequency of border crossing:_____times/ □ Day □ Week □ Month □ year		
Passport country/citizenship	Type of ID:	ID document #:	Visa?: □ Yes □ No

For deceased persons, go to Section 5. Otherwise, continue below.

Home address:	City:	State/province:	Zip/postal code:
Country of residence:	Home telephone:	If visiting, total duration of U.S. stay:_____ □ Days □ Weeks □ Months □ 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 Number of days reachable at contact phone: _____	
Emergency contact name:	Emergency contact relationship:	Emergency contact phone:	

Section 4. Border Crossing Information

License plate #:	State/province/country issued:	Attempted entry outside an official POE?: □ Yes □ No □ Unknown	Contact information collected on conveyance passengers/driver(s)?: □ Yes □ No □ Unknown

Crossing Type*	From (City/Country)	Departure date	To (City/Country)	Arrival date	Significant stops	Name of commercial carrier, if applicable	Bus/Train #	Seat #
Current Segment:								
Past & Upcoming Segments:								

*Crossing Type: **V**: Personal vehicle **TC**: Taxi cab **M**: Motorcycle **P**: Pedestrian/Bike **B**: Passenger bus **CC**: Commercial cargo vehicle **A**: Ambulance **T**: Train **O**: Other

Section 5. Disposition of 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 continue travel □ Transported to hospital (□ MOA activated): _____ □ Transported to non-hospital location: _____ □ Detained by law enforcement, location: _____ □ Denied entry by law enforcement □ Other: _____	Body released to medical examiner?: □ Yes □ No Medical examiner telephone: _____ City/State/Country: _____