



Air Travel Illness or Death Investigation Form

U.S. Centers for Disease Control and Prevention

Form Approved
OMB Control No.0920-0821
Exp XX/XX/XXXX



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: <input type="checkbox"/> Illness <input type="checkbox"/> Death | 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 | | |
| Where was the traveler when the QS was notified?: <input type="checkbox"/> In U.S. jurisdiction / Inbound <input type="checkbox"/> In foreign jurisdiction / Outbound <input type="checkbox"/> Unknown | <input type="checkbox"/> During travel | | |
| | <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 | | | |

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)? |
|--------------------|------------------|--------------|--|--|--|
| | | | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ |
| | | | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ |
| | | | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ |
| | | | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ |

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"/> Difficulty breathing/shortness of breath Onset date: ____/____/____ | <input type="checkbox"/> Decreased consciousness Onset date: ____/____/____ |
| <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"/> Swollen glands Onset date: ____/____/____ Location: <input type="checkbox"/> Head/neck <input type="checkbox"/> Armpit <input type="checkbox"/> Groin | <input type="checkbox"/> Recent onset of focal weakness and/or paralysis Onset date: ____/____/____ |
| <input type="checkbox"/> Conjunctivitis/eye redness Onset date: ____/____/____ | <input type="checkbox"/> Vomiting Onset date: ____/____/____ Number of times in past 24 hrs? ____ | <input type="checkbox"/> Unusual bleeding Onset date: ____/____/____ |
| <input type="checkbox"/> Coryza/runny nose Onset date: ____/____/____ | <input type="checkbox"/> Diarrhea Onset date: ____/____/____ Number of times in past 24 hrs?: ____ | <input type="checkbox"/> Obviously unwell |
| <input type="checkbox"/> Persistent cough Onset date: ____/____/____ <input type="checkbox"/> With blood <input type="checkbox"/> Without blood | <input type="checkbox"/> Jaundice Onset date: ____/____/____ | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Sore throat Onset date: ____/____/____ | <input type="checkbox"/> Headache Onset date: ____/____/____ | <input type="checkbox"/> Chronic condition |
| | <input type="checkbox"/> Neck stiffness Onset date: ____/____/____ | <input type="checkbox"/> Asymptomatic |
| | | <input type="checkbox"/> Other: _____ _____ _____ |

| 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?: <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/> Unknown *If yes, please fill in a new form for each person in the cluster | | | | | | | | | |
| Response or Info Only: <input type="checkbox"/> Requires DGMQ Response & Follow-up (Proceed to next section) <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of birth: _____ / _____ / _____ mm dd yyyy | 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 O = Other | | | | | | | | | |
| Section 5: Disposition of ill/deceased person | | | | | | | | | |
| Ill person was (check all that apply): | | | Deceased Person: | | | | | | |
| <input type="checkbox"/> Released to continue travel <input type="checkbox"/> Advised to seek medical care <input type="checkbox"/> EMS responded <input type="checkbox"/> Recommended to not travel <input type="checkbox"/> Transported to hospital (<input type="checkbox"/> MOA activated): _____ <input type="checkbox"/> Transported to non-hospital location: _____ <input type="checkbox"/> Detained by law enforcement, location: _____ <input type="checkbox"/> Denied entry by law enforcement <input type="checkbox"/> Other: _____ | | | Body released to medical examiner?: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical examiner telephone: _____ City/State/Country: _____ | | | | | | |

Public reporting burden of this collection of information is estimated to average 5 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 0920-0821.