

COMMUNICABLE DISEASES INFORMATION SHEETS

INTRODUCTION

The fact sheets presented here summarize communicable diseases that commonly affect students and school staff. They were designed to be used as educational and informational material for students, staff and parents, particularly when outbreaks occur in the school setting.

The primary resource for these fact sheets is Red Book: 2003 Report of the Committee on Infectious Diseases, 26th edition, American Academy of Pediatrics. Secondary references include: Control of Communicable Diseases in Man, 17th edition, American Public Health Association; Epidemiology and Prevention of Vaccine-Preventable Diseases, 2004, 8th edition, U.S. Department of Health and Human Services; Manual for Investigation & Control of Communicable Diseases in New Mexico, March 2003.

Several general methods of disease prevention that are available to schools listed below:

Surveillance	Observation for cases, monitoring the incidence (new cases) and prevalence (total cases) of diseases in the school population are the crux of surveillance.
Medical Evaluation	Referral of possible cases to a health care professional (the personal physician or other practitioner, clinic or the local Health Office) for evaluation (diagnosis) and treatment usually generates the medical evaluation.
Reporting to Department of Health	See list of reportable conditions; reports can be made to the local Health Office, to the District Health Officer or to the Office of Epidemiology, (505) 827-0006, at any time. Immediate reporting of highly contagious diseases like measles and shigellosis, serious conditions such as meningitis and outbreaks of gastroenteritis (vomiting or diarrhea) that may be due to a food or waterborne disease are especially important.
Contact prophylaxis	Some severe infections are likely to affect close contacts of cases and may be preventable by antibiotic prophylaxis (preventive treatment). Such treatment may be recommended by the Department of Health to close contacts within a classroom, athletic team or other school group.
Isolation	Isolation refers to the exclusion (e.g. from school) of a person with a communicable disease during the period of communicability.
Standard Precautions	An infection control practice that considers all persons' blood and body fluids potentially infectious for some pathogens is known as standard precautions. Thus, it is not necessary to know that a person is a carrier of a particular disease to protect one's self from exposure. Practices include avoidance of contact with blood, body fluids and excreta; wearing gloves when contact might occur; frequent hand-washing; decontamination of blood, etc. in the environment; and frequent washing and decontamination of counters, sinks, play areas, toys, etc.
Immunization	Schools are called upon to enforce the immunization statutes regarding routine immunizations. Some vaccine-preventable disease outbreaks occurring in schools have been controlled by school-based immunization programs. Immunization programs in schools also offer protection to older students before they leave the "captive population" of the school.
Prevention Education	Schools can model, teach and reinforce the simple habits of personal hygiene, environmental cleanliness and food-handling procedures that promote good health and minimize exposure to infectious diseases.

The format used for entry of each specific condition entertained in these guidelines includes the following topics.

Disease/ Condition	Proper and commonly used name of the disease or condition
Agent	Name of the infectious agent and its categorization (viral, bacterial, fungal, parasitic)
Clinical Description	Mechanism by which the disease is produced, typical symptoms and complications
Transmission/ Exposure	<p>Modes of Transmission</p> <ul style="list-style-type: none"> ▪ Direct: Individual to individual, such as exchange of body fluids, exposure to droplets from the nose or mouth or hand-to-hand contact ▪ Indirect: From an inanimate object, such as hard surfaces, tissues or dishes <p>Routes of Exposure</p> <ul style="list-style-type: none"> ▪ Inhalation: Airborne (from a sneeze or cough) ▪ Contact: Actual contact of some kind, such as contact with body fluids through an opening in the skin, mucous membrane, sexual contact or contaminated equipment ▪ Ingestion: Swallowing ▪ Intermediary: A vector-borne transmission, such as flea, mosquito or rodent
Contagious Period	<p>Period of time infection that the infectious agent can be passed to another person, sometimes beginning before symptoms develop and lasting until after recovery</p> <p>[Many infections are subclinical (do not produce symptoms), but the person is still contagious. A carrier state may occur if the agent continues to be present in a contagious form either before or after the illness.]</p>
Incubation	Period of time between exposure to an infectious agent and the onset of symptoms
Diagnosis	<p>Method by which the cause or nature of a disease or condition is determined</p> <p>[Clinical diagnosis is determined by physical examination; laboratory diagnosis by lab testing.]</p>
Management of Case	Steps to be taken in diagnosis and treatment of the person with the condition, including a requirement for exclusion from school
Management of Contacts	Steps to be taken in prevention of infection in persons who have been exposed to infection
Immunization	Availability and recommended use of vaccines and impact of immunization in control of the disease
Public Health Action	Requirement for reporting of diseases or conditions to the NM Department of Health and the action to be taken by the Department of Health
Prevention Education	Information on behaviors that individuals can adopt to reduce exposure to communicable diseases
School Action	Summary of actions by schools to detect and manage communicable diseases in the school community

Condition, Disease, Agent	<u>ANIMAL or HUMAN BITE INFECTION:</u> Bacterial agents include Streptococcus, Staphylococcus, Pasteurella, Bartonella (cause of cat-scratch fever); viral includes herpes simplex, hepatitis B and C, rabies
Clinical Description	An infected bite wound may cause increasing pain and swelling, redness, warmth and discharge of pus or bloody/serous fluid. Herpes simplex infections of these wounds show blisters and ulcers.
Transmission, Exposure	Bacteria or virus present in the mouth or throat of a person or animal inoculated into a bite or scratch contaminated with saliva.
Contagious Period	Bacteria, herpes simplex and other viruses can be carried indefinitely by a healthy person or animal. Rabies virus is present in saliva for a few days before the onset of symptoms.
Incubation	Depends on agent: 1-5 days for bacteria or herpes simplex virus, several weeks for cat scratch fever, weeks or months for rabies or hepatitis B.
Diagnosis	Cultures or serologic tests are required to determine the specific cause.
Management of Case	<p>First aid for all bites using standard precautions is very important. Control bleeding with local pressure over a clean cloth or sterile gauze dressing. Immediately wash the wound with water and antibacterial soap rinse thoroughly. Cover wound with a loose sterile dressing. Refer to physician for further management.</p> <p>Report all animal bites to the local Animal Control Officer and provide the name, age, home address and phone number of the victim as well as a description and location of the animal. Do not kill the animal unless necessary to protect the safety of human or other domestic animals. If it is necessary to kill the animal, attempt to preserve the head and brain intact for rabies testing.</p>
Management of Contacts	Review the health and immunization records of the biter and the victim. If the victim has been immunized against hepatitis B, it is very unlikely that he/she would be infected regardless of the infection status of the biter. If preventive treatment for hepatitis B is needed, it should be given as soon as possible.
Public Health Action	Report animal bites to the Animal Control Officer as described above. Confine and immunize domestic animals.
Prevention Education	Teach children to avoid unfamiliar domestic animals and all wild or stray animals. Children should not feed or handle animals. Ill or injured animals present special hazards.

School Action	<ul style="list-style-type: none"> ▪ Apply first aid for wounds and possible shock. ▪ Clean and bandage wound and refer victim to physician or emergency facility. ▪ Report animal bites and stray or injured animals to the Animal Control Officer (as described above). ▪ Offer prevention education.
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Condition, Disease, Agent	<u>BACTERIAL ENTERITIS</u> Salmonella, Shigella, Campylobacter, E. coli O157-H7, Yersinia enterocolitica
Clinical Description	Often acute onset of diarrhea with abdominal pain/cramps, fever, nausea and vomiting, headache and malaise. Stools may be watery or mucoid and may become bloody. Potential complications: dehydration, bacteremia and distant infection, hemolytic uremic syndrome.
Transmission, Exposure	Person to person or animal to person by fecal-oral route and by contaminated food, milk or water. Shigella is carried only by humans. Salmonella is carried by many animals including reptiles and may be transmitted by contaminated eggs, meat and milk. Campylobacter is carried by poultry and domestic animals: E. coli O157 and Yersinia enterocolitica by cattle; they may be transmitted by contaminated milk, meat and water or produce contaminated with manure.
Contagious Period	Shortly before onset of symptoms, during the symptomatic illness, and sometimes after the bacterial shedding has stopped as with Salmonella.
Incubation	Typically 24-72 hours (range 12 hours to a week or longer).
Diagnosis	Through culture of feces to determine etiology.
Management of Case	<p>Begin hydration with increased intake of plain water or other fluids at the onset of diarrhea. Children with other than mild to moderate watery diarrhea without fever or vomiting should be sent home. Refer for medical evaluation if fever, substantial abdominal pain, inability to maintain hydration are present or stools are bloody or contain pus. Some enteric infections may be treated with prescribed antibiotics. Any person with infectious diarrhea must avoid handling food. Persons with Salmonella, Shigella and E. coli O157 should not handle food until stool cultures are negative for the pathogen.</p> <p>Mild diarrhea is not usually a cause for exclusion from school if the student practices good hygiene. Children in diapers or with poor hygiene should be excluded if environmental contamination cannot be avoided. Children may return to school or daycare when symptoms are subsiding and do not interfere significantly with school activities. Any person with infectious diarrhea must avoid handling food. Persons with Salmonella, Shigella and E.Coli 0157-H7 should not handle food until cultures are negative for the pathogen.</p>
Management of Contacts	Surveillance for secondary cases. Contacts should practice good personal hygiene, especially hand washing and careful food handling.
Public Health Action	Report outbreaks of bacterial enteritis and possible food or waterborne outbreaks to the Department of Health (DOH). The Epidemiology Office will coordinate outbreak investigation and management. Individual cases of Salmonella, Shigella, Campylobacter, E.coli 0157-H7, Yersinia should be reported to DOH.
Prevention Education	Prevention requires good personal hygiene, especially hand washing after using the toilet and changing diapers and before preparing food or eating; environmental hygiene including safe food handling (separating raw and cooked food, washing utensils, counters and cutting boards).

School Action	<ul style="list-style-type: none"> ▪ With acute diarrhea of any cause, prevent dehydration by increasing fluid intake. ▪ Students with fever, vomiting or diarrhea should be sent home. Refer persons who have diarrhea with fever, bloody or pus containing stools for medical evaluation. ▪ Students may return to school when afebrile and diarrhea has decreased to the extent that they can participate in normal activities. ▪ Report outbreaks of diarrhea to the DOH immediately, especially if there is a suspicion of food or water transmission. ▪ Frequent hand washing should be stressed with students and staff.
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Condition, Disease, Agent	<u>CHICKEN POX (VARICELLA)</u> Varicella zoster virus
Clinical Description	Fever, malaise and non-descript respiratory symptoms (usually including cough) 1-2 days, followed by crops of skin lesions. Each lesion evolves from a flat to a raised pink spot to a vesicle (a tiny blister) on a pink or red base ("dewdrop on a rose petal"), pustule (pimple), and crusted pustule. Lesions appear first on face (behind ears) and trunk spreading to extremities; they may involve eyes and mucous membranes. The rash is usually quite itchy. Impetigo and deep skin infections may occur involving lesions which have been scratched. Severe, progressive or disseminated varicella is unusual in children with normal host defenses but may be fatal in children with leukemia or other immune impairment.
Transmission, Exposure	Person to person by direct contact with respiratory secretions and skin lesions; highly contagious.
Contagious Period	48 hours before onset of respiratory symptoms (2-3 days before onset of rash) until all skin lesions have crusted, usually 5-7 days.
Incubation	About 14 days (range 10-21 days).
Diagnosis	Clinical diagnosis is reliable when the presentation is typical and varicella is known to be present in the community.
Management of Case	Children with varicella should not be treated with aspirin since it may increase the risk of Reyes syndrome. Initial or sporadic cases of chicken pox should be confirmed by a physician. Any child with apparent chicken pox should be excluded from school until all lesions have crusted or until six days after onset of rash.
Management of Contacts	Refer immune-impaired susceptible contacts (with leukemia, cancer, organ transplantation and under treatment with immunosuppressive drugs) to their physician immediately for passive immunization with varicella-zoster immune globulin (VZIG) after exposure.
Immunization	Varicella vaccine is highly effective in prevention of chicken pox even in immune impaired individuals. It may not be effective in preventing infection if given after exposure. All children who have not had chicken pox should receive vaccine.
Public Health Action	Report cases to the Department of Health. Encourage administration of vaccine.

School Action	<ul style="list-style-type: none"> ▪ In a known outbreak of varicella, children with apparent chicken pox should be excluded from school until all lesions have crusted or until six days after onset of rash. Children who are immune-impaired may continue to develop new vesicles for a longer period and should be excluded until all lesions have become dry and are crusted. It is not necessary for lesions to have healed completely. ▪ Report cases to the Department of Health.
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Condition, Disease, Agent	<u>CHLAMYDIA, GONORRHEA</u> Chlamydia trachomatis (CT, bacteria-like); Neisseria gonorrhoeae (GC, bacteria)
Clinical Description	These infections are described together because there is overlap in the clinical presentation, and dual infections are common. CT and GC infect mucous membranes resulting in inflammation with burning on urination and urethral or vaginal discharge; infections of other sites may cause sore throat, conjunctivitis, rectal pain and discharge, etc. Complications include pelvic inflammatory disease (PID) in women and epididymitis in men. PID is responsible for an epidemic of tubal infertility and ectopic pregnancy in the US. Disseminated GC with arthritis, tenosynovitis and skin lesions occurs infrequently.
Transmission, Exposure	Both are readily transmitted by intimate (mucosal) contact with infectious secretions. CT conjunctivitis can be caused by self-inoculation of the eye by a person with genital infection. It is readily transmitted by sharing eye makeup. Sexual contact with an infected individual may result in genital, throat and rectal infections.
Contagious Period	If untreated, the infected individual may remain contagious indefinitely; after treatment the contagious period is one to several days.
Incubation	GC is 2-5 days after exposure; CT is 7-14 days.
Diagnosis	Examination may reveal inflammation (tenderness, swelling, pus discharges) of the infected genitals or eyes. Laboratory testing by DNA probes is highly sensitive and specific. Bacterial culture for GC is recommended.
Management of Case	Suspected cases should be referred for medical evaluation and treatment. Minors may seek care for sexually transmitted disease without parental knowledge or consent. In addition to GC and chlamydia, at risk individuals should be evaluated for other sexually transmitted diseases. School exclusion is not necessary. Gonococcal and genital or rectal chlamydial infections in young children indicate that at least inappropriate sexual contact has occurred; refer children under the age of consent and older children who give a history of sexual assault to Child Protective Services and/or other appropriate authority.
Management of Contacts	Intimate (sexual) contacts of infected individuals should be evaluated for infection and treated.
Preventive Education	Postpone sexual activity and limit partners; use condoms. Nonoxynol spermicides have some antimicrobial effect and may enhance the efficacy of condoms.
Public Health Action	Report gonorrhoea and chlamydial infections to the Department of Health.

School Action	<ul style="list-style-type: none"> ▪ Support school-based clinics, peer counseling, and education to increase availability and acceptability of health care services to adolescents. ▪ Refer students to physician, Department of Health or school-based clinic for diagnosis and treatment. ▪ School exclusion not necessary. ▪ Consider the possibility of child or sexual abuse and refer to Child Protective Services as appropriate.
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Condition, Disease, Agent	CONJUNCTIVITIS, ACUTE (PINK-EYE) Adenovirus, enteroviruses and many respiratory viruses and Hemophilus aegyptius and other bacteria.
Clinical Description	Infectious conjunctivitis produces a variably red eye with swelling and discharge which may be watery or with mucus or pus and crusting of the eyelids. Discomfort ranges from minimal itching or a grainy sensation to substantial pain, sometimes mild photophobia (light sensitivity) or blurring of vision. In contrast, allergic conjunctivitis is usually accompanied by other signs of allergy (red conjunctiva; swollen, itching eyelids; nasal congestion, watery eye and nasal discharge, sneezing).
Transmission, Exposure	Person-to-person by contact with infected secretions from the eye or respiratory tract either directly or through contact with contaminated objects such as shared towels or eye make-up. Viral conjunctivitis is highly contagious. Bacterial conjunctivitis is somewhat less contagious and antibiotic treatment reduces the period of communicability.
Contagious Period	Usually at least one day before onset of symptoms until symptoms are clearly subsiding or after 24 hours of antibiotic treatment.
Incubation	1-3 days for most respiratory viruses, 2-7 days for bacteria.
Diagnosis	Diagnosis is through clinical evaluation. Definitive diagnosis usually requires culture of the eye.
Management of Case	Refer students with conjunctivitis for medical evaluation and treatment. An outbreak of conjunctivitis requires determination of the cause. Specific antibiotic treatment is available for conjunctivitis due to bacterial infection. Exclusion from school is usually not necessary if a child can practice frequent hand washing. In the case of outbreaks of bacterial conjunctivitis, a patient is considered non-contagious after 24 hours of antibiotic therapy.
Management of contacts	During outbreaks, prevention depends on scrupulous personal hygiene therapy. Outbreaks of viral conjunctivitis will usually run their course in a relatively closed community such as a school. Bacterial conjunctivitis may require intensive surveillance to detect new cases as early as possible.
Public Health Action	Report school outbreaks of conjunctivitis to the Department of Health.
Prevention education	Hand-washing and avoidance of touching one's eyes are the defense against eye and respiratory infections. Avoid sharing towels, eye makeup and other items that may be contaminated with infectious discharges.

School Action	<ul style="list-style-type: none"> ▪ Refer children with eye irritation or discharge for medical evaluation and treatment. Report outbreaks to the Department of Health for assistance in management. ▪ School exclusion is usually not necessary for isolated cases but may be necessary for control of outbreaks. The school nurse may exclude an individual based on his/her clinical judgment. ▪ Offer prevention education.
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Condition, Disease, Agent	<u>CYTOMEGALOVIRUS INFECTION (CMV)</u> Cytomegalovirus
Clinical Description	Mononucleosis-like syndrome with fever, malaise, and mild enlargement of lymph nodes is common in older children and adults. Infections range from sub-clinical (usual in young children) to severe systemic infection in the fetus and immune-impaired patients; manifestations may include hepatitis, pneumonia, encephalitis and chorio-retinitis. Complications for babies born after exposure of the virus from intrauterine infection may be normal or may be growth retarded, fail to thrive, have developmental delay, visual and hearing deficits. Severe disease in immune-impaired individuals, including AIDS, may result in blindness or respiratory failure.
Transmission, Exposure	Contact with infected secretions (saliva, urine, genital secretions) or by blood transfusion. Infected infants or children can infect their mothers and other caregivers because of prolonged virus shedding in the urine. CMV infection can be sexually transmitted; genital contact is the mode of transmission for the average young adult who becomes infected.
Contagious Period	Weeks to many months. The virus becomes latent and can reactivate with periodic viral shedding in saliva and urine.
Incubation	3-12 weeks
Diagnosis	Confirmation of infection requires positive culture (urine) and/or serology (IgM antibody).
Management of Case	Most treatment is symptomatic. Treatment of life/sight-threatening infection with antiviral drugs is at least temporarily effective. Exclusion from school is not necessary.
Management of Contacts	Avoid contact with urine and saliva. Personnel who care for non-toilet-trained children or who come in contact with saliva or other body fluids or secretions should practice careful personal hygiene, especially hand washing. Wash contaminated toys and other objects regularly. Women who are pregnant or trying to become pregnant may wish to consult their physician to determine whether they are susceptible.
Public Health Action	Reporting is not required.
Prevention Education	Hand washing after using toilet, changing diapers, assisting children with toileting and contact with saliva.

School Action	<ul style="list-style-type: none"> ▪ Emphasize personal and environmental hygiene and standard precautions. ▪ School exclusion is not appropriate.
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Condition, Disease, Agent	<u>DIARRHEA (Acute)</u> Viral Diseases: Rotavirus, Norwalkvirus, Adenovirus. Coronavirus. Bacterial Agents: Salmonella, Shigella, Campylobacter, Vibrio, Yersinia, E. coli O157-H7, Staphylococcus, Bacillus cereus, Clostridium. Parasitic Agents: Giardia, Cryptosporidium, Entamoeba histolytica.
Clinical Description	Gradual to explosive onset of diarrhea with or without fever, nausea, vomiting, abdominal pain, and/or systemic toxicity.
Transmission, Exposure	Person-to-person by fecal/oral route and by contaminated food, water or milk. Environmental contamination may occur especially when changing diapers.
Contagious Period	Generally, patients are contagious while symptomatic; asymptomatic carrier states may occur.
Incubation	Usually 1-3 days for viruses; 2-4 days for bacteria; often weeks for parasites.
Diagnosis	Diagnosis requires culture for bacteria and microscopic exam or antigen testing for parasites.
Management of Case	Begin hydration with increased intake of plain water or other fluids at the onset of diarrhea. Refer for medical evaluation if fever, substantial abdominal pain, inability to maintain hydration are present or stools are bloody or contain pus. Children with diarrhea should be considered for exclusion from school primarily because of hygiene issues. Children in diapers should be considered for exclusion if environmental contamination cannot be avoided. Those excluded may return to school or daycare when under appropriate treatment (if treatment is indicated) and when symptoms do not interfere with routine school activities. Any person with infectious diarrhea should avoid handling food. Persons with bacterial diarrhea should avoid handling food until stool cultures are negative for the pathogen.
Management of Contacts	Testing of asymptomatic contacts may be necessary to control outbreaks. Contacts should practice good personal hygiene, especially hand washing and careful food handling.
Public Health Action	Report outbreaks of diarrhea and especially gastroenteritis suggestive of a food, milk or waterborne outbreak to the Department of Health.
Prevention Education	Prevention requires good personal hygiene (hand washing after using the toilet and changing diapers and before preparing food and eating) and kitchen hygiene (separating raw and cooked food, washing utensils, counters and cutting boards). Community prevention requires a safe water supply and uncontaminated food and milk.

School Action	<ul style="list-style-type: none"> ▪ With acute diarrhea of any cause, prevent dehydration by increasing fluid intake. ▪ Students with fever, vomiting or diarrhea that interferes with school activity should be sent home and excluded from school until symptoms do not interfere with routine school activities. ▪ Refer persons who have diarrhea with fever, bloody or pus containing stools for medical evaluation. ▪ Students may return to school when afebrile and diarrhea has improved to the extent that they can participate in normal activities. ▪ Report outbreaks of diarrhea to the Department of Health immediately, especially if there is a suspicion of food or water transmission. ▪ Frequent hand washing should be stressed by all school staff. ▪ Offer prevention education.
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Condition, Disease, Agent	<u>FIFTH DISEASE (ERYTHEMA INFECTIOSUM)</u> Human parvovirus B19
Clinical Description	Symptoms are a mild fever in a minimally ill child with flushed cheeks or bright red and slightly edematous "slapped" cheeks. Later in the infection, a lace-like or lattice-like rash may appear on the trunk and extremities accentuated by heat or sunlight. Many children have a history of mild gastroenteritis or upper respiratory infection a week previously. Older children and adults typically have transient arthritis lasting a few days.
Transmission, Exposure	Person-to-person transmission by droplets or contact with respiratory secretions or saliva. Subclinical and atypical infections are very common and are contagious.
Contagious Period	Approximately one week before the rash appears; usually not contagious by the time the rash develops. Immune-impaired patients and those with aplastic crisis may be contagious for a prolonged period.
Incubation	4 to 21 days
Diagnosis	Clinical diagnosis of typical disease occurring in outbreaks is reliable. The diagnosis can be confirmed by serology (IgM antibody)
Management of Case	There is no specific treatment, but most cases in children resolve promptly with no need for intervention. School exclusion is not beneficial because transmission to other susceptible individuals will have occurred before the infection is recognized.
Management of Contacts	Parents of children with chronic anemia or immune deficiency and pregnant women should be notified of possible exposure. Pregnant women may wish to determine their immune status.
Prevention education	Frequent hand washing will minimize the risk of exposure.
Public Health Action	Report outbreaks and infections with complications to the Department of Health.

School Action	<ul style="list-style-type: none"> ▪ School exclusion is not helpful. ▪ Notify parents of children with chronic anemia or immune deficiency and pregnant women when outbreaks occur. ▪ Frequent hand washing should be stressed by school staff.
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Condition, Disease, Agent	<u>GENITAL WARTS</u> Human Papillomavirus (HPV)
Clinical Description	Single or massed warty or cauliflower-like growths may be found on external genitals, urethral opening, anus, and inside the vagina. They may cause irritation. Some strains cause neoplasia of the cervix and other genital structures.
Transmission, Exposure	Person-to-person genital contact and possibly by contaminated articles.
Contagious Period	May be indefinite but probably at least as long as lesions exist
Incubation	2-3 months with a range of 1-20 months
Diagnosis	The typical lesion usually confirms diagnosis, but it should be excised and examined histologically. Microscopic examination of cells is an effective method for detecting cellular abnormalities associated with malignancy in women.
Management of Case	Treatment which may be chemical or physical destruction will decrease the amount of wart virus available for transmission. The warts may regress spontaneously within months to years. Avoidance of direct contact with lesions by others prevents transmission. Studies have indicated that the male condom does not prevent infection. School exclusion is not helpful.
Management of Contacts	Sexual contacts of patients with venereal warts should be examined and treated if indicated.
Prevention education	Avoidance of contact with lesions on another person prevents infection.
Public Health Action	Not reportable to Department of Health in New Mexico.

School Action	<ul style="list-style-type: none"> ▪ School exclusion is not appropriate. ▪ Offer prevention education as part of sex education curriculum.
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Condition, Disease, Agent	<u>GIARDIASIS, CRYPTOSPORIDIOSIS</u> Giardia lamblia, Cryptosporidium (protozoan parasites)
Clinical Description	Diarrhea with loss of appetite, nausea, abdominal discomfort and flatulence. Patients may have altered sense of taste or a metallic taste and frequently note headache, malaise and similar non-specific toxic symptoms. The diarrhea is often chronic and/or recurrent and may alternate with constipation; symptoms may last for weeks or months. Individuals may carry the parasite without symptoms (asymptomatic carriers).
Transmission, Exposure	Contamination with animal and human feces has resulted in the presence of Giardia cysts in virtually all untreated surface water. Transmission by food prepared by infected individuals or those caring for diapered infants with giardiasis has resulted in outbreaks. Person-to-person transmission by caretakers and children in day care institutions has resulted in outbreaks involving substantial proportions of the children at risk. Only a small number of viable cysts (10-100) are required to establish infection, especially in persons with reduced stomach acidity.
Contagious Period	Variable; an untreated case may continue to excrete Giardia cysts indefinitely.
Incubation	Less than 1 week to more than 4 weeks.
Diagnosis	Identification of parasites by microscopic exam or antigen test (EIA) in the stool or by antigen testing. Repeated examinations may be necessary especially if the infection is chronic.
Management of Case	Symptomatic patients and asymptomatic carriers implicated in transmission of infection should be treated. As long as sanitation is adequate, there is no reason to exclude a child with giardiasis or cryptosporidium from school.
Management of Contacts	Personal hygiene, surveillance.
Public Health Action	Notify the Department of Health of outbreaks. The Epidemiology Office will coordinate outbreak investigation and management. In some cases, stool surveys within a school may be indicated. Evaluation of the water supply for fecal contamination may be indicated.
Prevention Education	Avoid contact with animals with diarrhea. Wash hand carefully after using the toilet or changing diapers and before preparing food and eating.

School Action	<ul style="list-style-type: none"> ▪ Refer suspected cases for diagnosis and treatment. ▪ Report outbreaks to the Department of Health. ▪ School exclusion is usually not necessary unless the child is unable to maintain continence of stool. ▪ Offer prevention education.
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Condition, Disease, Agent	<u>HANTAVIRUS PULMONARY SYNDROME (HPS)</u>
Clinical Description	The prodromal illness consists of fever and myalgia with variable respiratory symptoms, abdominal pain, vomiting or diarrhea. PHS symptoms of progressive cough, shortness of breath and dizziness reflect cardio-respiratory insufficiency.
Transmission, Exposure	Contract with aerosolized rodent feces and urine (mainly deer mice) is the presumed mode of transmission. Indoor exposures in closed, poorly ventilated homes, vehicles and outbuildings with visible rodent infestations are especially prominent.
Contagious Period	No person-to-person infections of the disease has been documented in North America.
Incubation	1-3 weeks
Diagnosis	Clinical diagnosis is made by demonstration of specific IgM antibodies in specialized laboratory testing.
Management of Case	There is no specific treatment; supportive care includes respiratory intensive care. Bed rest and early diagnosis are critical in disease outcome. School exclusion is not needed.
Management of Contacts	None.
Prevention education	Exterminate rodents in home and avoid contact with rodents. Store human and animal food in rodent proof containers, and disinfect rodent contaminated areas by spraying a disinfectant such as dilute bleach solution prior to cleaning. Avoid inhalation of dust in infested areas by wearing approved respirators when cleaning these areas.
Public Health Action	Report outbreaks and infections to the Department of Health.

School Action	<ul style="list-style-type: none"> ▪ School exclusion is not appropriate. ▪ Provide prevention education.
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Condition, Disease, Agent	<u>HEPATITIS A (Acute)</u> Hepatitis A virus
Clinical description	Symptoms include fever, nausea, vomiting, loss of appetite, or distaste for certain foods or cigarettes followed in 3-10 days by dark brown urine, pale feces and jaundice (yellow discoloration of eyes, skin and mucous membranes). About 80% of hepatitis A infections in young children are without symptoms or are a gastroenteritis-like illness without jaundice compared to 50% of infections in school-age children and 20% in adults.
Transmission, Exposure	Person-to-person by fecal-oral mechanism both direct and indirect. Contaminated food or water may lead to outbreaks. Secondary cases occur in families and other close groups where people share food, drinks, and/or cigarettes.
Contagious Period	From 1-2 weeks before onset of symptoms until a week or two after onset of jaundice.
Incubation	Usually 25-30 days with a range 15-50 days.
Diagnosis	Exam shows jaundice with liver enlargement and tenderness as with other types of hepatitis. Laboratory testing results in elevated enzymes (SGPT/ALT), and elevated bilirubin reveals mild to severe liver injury. Hepatitis A IgM antibody is usually present at the onset of jaundice.
Management of Case	Refer children with jaundice for medical evaluation. Children may be too sick to attend school during the acute phase of illness. Those with a clinical diagnosis of Hepatitis A should be excluded until one week after onset of jaundice.
Management of Contacts	Close contacts should be given immune globulin (IG) as soon as possible after exposure. Older children are less likely to spread hepatitis A within the classroom. If hepatitis A transmission occurs within a school, students and staff in the same classroom may be given IG prophylaxis. Hepatitis A vaccine has not been approved for post-exposure preventive use as a substitute for IG.
Immunization	Hepatitis A vaccine is being recommended for children in high incidence communities in NM. The vaccine can be given to children two years of age or older and provides 90-95% protection after the first dose (a booster is recommended to produce longer lasting immunity). Hepatitis A vaccine may also be recommended to school populations when one or more students have acute hepatitis A.
Public Health Action	Report cases of suspected hepatitis to the Department of Health. Confirmed cases will be investigated and contacts will be given treatment. Promote vaccination of children at increased risk of exposure.
Prevention Education	Hand washing after using the toilet, changing diapers and assisting children with toileting, and before handling food and eating is the most important preventive measure. Keeping toilet and food preparation areas clean and will minimize risk of disease transmission.

School Action	<ul style="list-style-type: none"> ▪ Refer jaundiced children for medical evaluation. ▪ Report suspected cases to the Department of Health. ▪ Consider exclusion of Hepatitis A confirmed cases until one week after onset of jaundice. ▪ Encourage use of IG and hepatitis A vaccine as recommended by the Department of Health.
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Condition, Disease, Agent	<u>HEPATITIS B and C (Acute)</u> Hepatitis B virus (HBV) and hepatitis C virus (HCV)
Clinical Description	Symptoms may include anorexia, nausea, malaise, jaundice, arthritis and skin rashes. Complications may include liver failure, chronic hepatitis and eventual cirrhosis or liver cancer.
Transmission, Exposure	Usually by direct and indirect contact with infected blood or body fluids or objects contaminated with blood or genital secretions. Contact may be parenteral (injection drug use, accidental needle stick, drug use or transfusion) or by sexual contact; HB can potentially be transmitted by close family contact (e.g. sharing toothbrushes).
Contagious Period	Virus is present in the blood, secretions and body fluids containing blood, and for HBV in genital secretions (semen, vaginal fluid) for a few weeks before onset of symptoms. Chronic carrier states are common (5-20% of those infected with HBV, perhaps 90% infected with HCV).
Incubation	HBV is an average of 90 days with a range of 145-160 days. HCV is usually 40-50 days with a range of 12-50 days.
Diagnosis	Serology for acute hepatitis B usually shows hepatitis B surface antigen and IgM antibody to core antigen (IgM anti-HBc). Serology for hepatitis C is a test for total antibody (anti-HCV).
Management of Case	Refer children with suspicion of hepatitis for medical evaluation. School exclusion is not needed; the child may be too ill to participate in school activities.
Management of Contacts	Contacts of hepatitis B and C should be evaluated for risk of infection. Needle sharing, sexual contact or close family contact is indication for serologic testing and immunization.
Immunization	Infants should receive hepatitis B vaccine along with other routine immunizations. As of 2002 it is required for required for school entry in NM. Any person at increased risk of hepatitis B infection should receive vaccine.
Public Health Action	Report cases to the Department of Health. Promote immunization.
Prevention Education	Avoid contact with blood and body fluids; avoid injections, tattoos, etc with unsterile equipment. Practice safe sex including use of latex condoms. Persons who inject illicit substances (including steroids) should be encouraged to stop or to obtain sterile equipment or decontaminate equipment without sharing with others.

School Action	<ul style="list-style-type: none"> ▪ Refer children with jaundice or other suspicion of hepatitis for medical evaluation. ▪ Monitor immunization status of students. ▪ Report confirmed cases to the Department of Health. School exclusion is not necessary. ▪ Observe standard precautions. Evaluate students who are chronic carriers of HBV for behavior that may place others at risk (biting for example). ▪ School staff identified at high-risk for exposure to HBV in the school districts bloodborne pathogen exposure plan should receive hepatitis B vaccine. ▪ Offer prevention education. ▪ Refer sexual contacts of an infected person to the Department of Health for testing and immunization. ▪ Respect the right to confidentiality of infected persons.
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Condition, Disease, Agent	<u>HERPES SIMPLEX-GENITAL INFECTION</u> Herpes simplex virus (HSV), type 2
Clinical Description	Symptoms include vesicles (small blisters) on the skin and/or mucus membranes that rupture quickly leaving painful ulcers and dry crusts (on skin); satellite vesicles form for several days with primary infection. There may be fever and malaise lasting 5 or more days following infection. Recurrent infections are common and usually occur in the same area as the primary lesion. Recurrent genital lesions may be initiated by trauma, emotional stress, menstruation, illness or fever. Recurrent lesions are usually smaller and heal more quickly. HSV may spread to the eye and cause inflammation and ulceration of the cornea.
Transmission, Exposure	Direct contact with genital secretions or lesion. Spread via toilets is highly unlikely although virus remains viable on contaminated objects at least for several hours.
Contagious Period	7-50 days following onset of a primary infection and for up to a week after onset of a recurrent episode. Patients may have asymptomatic shedding of the virus and may be capable of spreading the infection when they have no symptoms.
Incubation	2-14 days for primary infection.
Diagnosis	Diagnosis is made on the clinical appearance of lesions; they are initially thin-walled vesicles and/or blisters that ulcerate on moist surfaces or crust on dry skin. Laboratory testing includes cultures to confirm diagnosis.
Management of Case	Refer for medical evaluation for apparent primary infection or for frequent or severe recurrences. Genital herpes in a school child may be indicative of sexual abuse. Specific treatment: Oral (or in severe cases, intravenous) acyclovir is effective in shortening the duration of the primary episode including viral shedding. Patients with frequent recurrences may be able to suppress them with continuous oral acyclovir.
Management of Contacts	Genital herpes infection will not be spread under ordinary circumstances within the school environment.
Public Health Action	Herpes simplex is not a reportable condition.

School Action	<ul style="list-style-type: none"> ▪ Support school-based clinics, peer-counseling, education, and other measures to increase availability and acceptability of health care services to adolescents. ▪ Affected students should not be excluded from school. ▪ If sexual abuse or inappropriate sexual contact is suspected, the situation should be reported to Child Protective Services or other appropriate authority. ▪ Preventive education should include safe sex practices. ▪ Good hand washing practice should be stressed by school staff.
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**Condition,
Disease, Agent**

HERPES SIMPLEX, NON-GENITAL INFECTIONS
Herpes simplex virus (HSV) - Type 1

**Clinical
Description**

Symptoms include vesicles (small blisters) on the skin and/or mucus membranes that rupture quickly leaving painful ulcers and dry crusts (on skin), satellite vesicles form for several days with primary infection. There may be fever and malaise lasting 5 or more days. Recurrent infections are common and usually occur in the same area as the primary lesion. "Cold sores" and "fever blisters" may be initiated by trauma, emotional stress, menstruation, illness or fever. Recurrent lesions are usually smaller and heal more quickly. Herpes gladiatorum is a herpetic skin infection (usually HSV-1) usually of the trunk or extremities of wrestlers and other athletes probably resulting from salivary inoculation of minor skin abrasions. HSV-1 may spread to the eye and cause inflammation and ulceration of the cornea. Patients with eczema (and rarely other types of dermatitis) are at risk for widespread herpetic infection of their skin lesions (called eczema herpeticum).

**Transmission,
Exposure**

Non-genital lesions (usually HSV-1): contact with saliva or with the open lesions. A child with oral lesions can inoculate their eye, genitals, thumb or fingers or other areas of skin.

**Contagious
Period**

7-50 days following onset of a primary infection and for up a week after onset of a recurrent episode. Patients may have asymptomatic shedding of the virus and may be capable of spreading the infection when they have no symptoms.

Incubation

2-14 days for primary infection.

Diagnosis

The diagnosis is made on the clinical appearance of the lesions; they are initially thin-walled vesicles and/or blisters that ulcerate on moist surfaces or crust on dry skin. Laboratory testing includes cultures to confirm diagnosis.

**Management of
Case**

Refer for medical evaluation for apparent primary infection or for frequent or severe recurrences. Specific treatment: Oral (or in severe cases, intravenous) acyclovir is effective in shortening the duration of the primary episode including viral shedding. Patients with frequent recurrences may be able to suppress them with continuous oral acyclovir.

**Management of
Contacts**

Protect children with eczema or severe immune deficiency and newborns from exposure to persons with active herpes infections. Covering lesions with clothing or a loose dressing will curtail most transmission since hand contact with lesions will be minimized.

**Public Health
Action**

Herpes simplex is not a reportable condition.

School Action	<ul style="list-style-type: none">▪ School exclusion is not necessary.▪ Infected students should be taught to wash frequently surfaces and objects routinely contaminated with oral secretions. Wash sports equipment (especially mats) after practice and competition▪ Persons in physical contact with students who have active lesions and who cannot control their oral secretions should wash their hands frequently and wear gloves for direct lesion or saliva contact.▪ Exclude athletes in contact sports from competition while they have open lesions that cannot be covered.
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Condition, Disease, Agent	<u>HIV INFECTION/AIDS (ACQUIRED IMMUNODEFICIENCY SYNDROME)</u> Human immunodeficiency virus (HIV)
Clinical Description	Initial infection with HIV may be subclinical or may cause an acute mononucleosis-like illness with fever, malaise, sore throat, lymph node enlargement and skin rash. Progressive symptoms may occur years later including fever, weight loss, chronic diarrhea or symptoms of opportunistic infection or cancer that occur when immune function becomes severely impaired. HIV infects cells of the immune system and causes progressive impairment of immune function. Early combination anti-retroviral treatment has prolonged the symptom-free period, delayed the onset of AIDS and prolonged the lives of HIV infected people.
Transmission, Exposure	Contact with blood or body fluids or genital secretions of an infected person commonly by sharing injection equipment or sexual contact with an infected person. Infants born to an infected mother may be infected at birth or by breast feeding. Infection is <u>not</u> a risk with casual household, school or social contact.
Contagious Period	A few weeks after infection to indefinitely since infection is chronic. Periods of greatest infectivity are soon after infection with HIV and with advanced HIV/AIDS illness.
Incubation	1-3 months to seroconversion for HIV infection. 1 to many years for development of AIDS.
Diagnosis	HIV infection can be suspected by clinical symptoms and signs, but laboratory confirmation requires testing for HIV antibodies using the Enzyme immunoassay (EIA) and/or Western Blot tests.
Management of Case	Children with HIV infection may be absent from school frequently and may need to be given medication frequently and regularly during the school day. They may be more susceptible to some infections and may not be completely protected by immunizations. Observing standard precautions with these students is especially important.
Management of Contacts	Casual contacts are not at risk of infection. People at risk are those who have unprotected sexual contact, share needles or syringes for injection of illicit drugs or have blood or body fluid contact with non-intact skin or mucous membranes with someone who is HIV positive. Such contacts should be tested and followed by a primary care physician. Post-exposure preventive treatment is recommended for any percutaneous exposure to blood from a person with known HIV infection. This anti-retroviral treatment must be given within 72 hours of exposure to be optimally effective. Such contacts should be referred for medical evaluation immediately. Any person at risk of HIV infection should be tested to facilitate early treatment.
Public Health Action	Report cases of HIV infection or AIDS to the Department of Health. Refer exposures who are uninsured to the Department of Health immediately for post-exposure preventive treatment and testing.
Prevention Education	Avoid contact with blood and body fluids; avoid injections, tattoos, etc with unsterile equipment. Practice safe sex. Persons who inject illicit substances (including steroids) should be encouraged to stop or to obtain sterile equipment or decontaminate equipment without sharing with others.

School Action	<ul style="list-style-type: none"> ▪ School exclusion is not needed (possible exceptions may occur with opportunistic infections (e.g. TB). Infected students may participate in all school activities compatible with their medical condition. ▪ Practice standard precautions and conform to OSHA regulations. ▪ Evaluate students for behavior that may place others at risk (biting for example). ▪ Provide prevention education. ▪ Respect the right to confidentiality of infected persons and provide them with as normal a school environment as possible.
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Condition, Disease, Agent	<u>IMPETIGO</u> Group A streptococci (GAS), Staphylococcus aureus, occasionally other bacteria
Clinical Description	Pustules, vesicles or bullae (small or large blister-like lesions), and crusted areas are most common. "Honey-colored" crusts are typical of streptococcal infection. Impetigo is more common in summer and early fall as a common complication of abrasions, insect bites and chicken pox. Outbreaks can occur in populations with much skin-to-skin contact and a high rate of GAS carriage.
Transmission, Exposure	Direct person-to-person contact of colonized skin or lesion to skin is probably the most common mode of transmission.
Contagious Period	Variable, probably at least while lesions are actively weeping and crusting; not contagious 24 hours after initiation of effective antibiotic.
Incubation	2-5 days with a range of 1-10.
Diagnosis	Clinical diagnosis is reliable but culture and sensitivity of the base of the lesion is recommended.
Management of Case	Both topical and systemic antibiotic are required to treat impetigo effectively. A child with this disease should not return to school until 24 hours after antibiotic treatment has been started; large weeping lesions should be covered by clothing or a loose dressing.
Management of Contacts	Careful surveillance of contacts and persons living in close contact (home and school). Improved personal hygiene will minimize the risk of infection of minor wounds.
Public Health Action	Outbreaks of impetigo and complications of streptococcal infection should be reported to the Department of Health.

School Action	<ul style="list-style-type: none"> ▪ Refer suspected cases for medical evaluation and treatment. ▪ Exclude infected students from school until after 24 hours of antibiotic treatment is completed. ▪ Stress good personal hygiene and avoidance of contact with lesions by unaffected. Monitor students with lesions and cover with clothing or a loose dressing as appropriate. ▪ Provide prevention education.
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Condition, Disease, Agent	<u>INFLUENZA</u> Influenza virus (types A and B)
Clinical Description	Acute respiratory infection ("flu") characterized by fever, chills or rigors, headache, malaise and diffuse myalgia and respiratory symptoms including sore/scratchy throat, nasal congestion and cough, usually initially harsh and dry then becoming productive of sputum. Abdominal pain, vomiting and diarrhea are not uncommon in children infected with influenza. Infections may be subclinical or very mild. Bacterial super-infections are relatively common, including bronchitis, pneumonia, otitis media and sinusitis.
Transmission, Exposure	Direct and indirect contact with respiratory secretions either by large droplets through sneezing and coughing or contact with contaminated surfaces or objects via hand inoculation of the eye and nose.
Contagious Period	3-5 days after clinical onset of symptoms.
Incubation	1-3 days.
Diagnosis	Clinical diagnosis is usually reliable when symptoms are typical and influenza is known to be present in the community. Direct tests for viral antigen can be used for rapid diagnosis. Cultures for influenza take more time for results but can identify the influenza type which is important in developing influenza vaccine.
Management of Case	Children and adults with clinical influenza should be sent home until fever (greater than 100°F) subsides. Fluids are important to maintain hydration. Bed rest, analgesics (other than aspirin) may help symptomatically. The symptomatic cough may persist for weeks and may require some limitation of activity, especially for children with asthma. Students should not return to school until afebrile (less than 100°F) and systemic symptoms have subsided (usually 3-7 days).
Management of Contacts	Immunize adults and children with current influenza vaccine.
Immunization	All children and adults at risk for influenza complications or in contact with persons at increased risk should receive vaccine annually as soon as it is available.
Public Health Action	Notify the Department of Health when outbreaks of respiratory disease appear in a school.
School Action	<ul style="list-style-type: none"> ▪ Exclude students and staff with clinical influenza until afebrile (less than 100°F) and symptoms are subsiding and do not affect participation in routine school activities. ▪ Report suspected outbreaks of respiratory disease to the Department of Health. ▪ Emphasize hand washing and respiratory droplet precautions in prevention education. ▪ Offer influenza vaccination to staff through school health program. ▪ Consider student absenteeism and staff availability when making decisions to close school when outbreaks occur.

Condition, Disease, Agent	<u>MENINGITIS (BACTERIAL) or MENINGOCOCCEMIA</u> Haemophilus influenzae, type b ("Hib"), Streptococcus pneumoniae (pneumococcus), Neisseria meningitidis (meningococcus)
Clinical Description	Invasive bacterial disease manifesting as fever, chills, malaise and rash that may be macular maculopapular or petechial. Sepsis and early meningitis are similar in clinical presentation and may co-exist. Sepsis may present with fever and systemic toxicity only while typical meningitis is characterized by fever, stiff neck, headache, vomiting, and possibly stupor or loss of consciousness. Potential complications include shock, respiratory failure, seizures, coma and death. Neurologic complications of meningitis include deafness, seizure disorders, acquired learning disabilities or developmental retardation, paralysis (cerebral palsy).
Transmission, Exposure	Direct person-to-person transmission through droplet spread or contact with respiratory secretions. The bacteria are carried in the throat or nasopharynx by asymptomatic individuals.
Contagious Period	Healthy carriers are potentially infectious. Patients with bacterial meningitis once started on appropriate antibiotic therapy are generally non-contagious within 24 hours.
Incubation	Usually 23-4 days with a range of 1-10 days.
Diagnosis	Examination of the spinal fluid and culture of blood and spinal fluid are required to confirm the clinical diagnosis and guide therapy.
Management of Case	Bacterial sepsis and meningitis are life-threatening illnesses requiring immediate hospitalization and antibiotic treatment. When the child has recovered, he/she may return to school with any limitations specified by the primary physician.
Management of Contacts	It is important to start surveillance of contacts of infected person for antibiotic prophylaxis. Secondary cases of <u>meningococcal disease</u> may occur in contacts of any age, so prophylaxis is indicated for face-to-face, household and close social contacts within the previous 7 days. Secondary cases of Haemophilus influenzae and pneumococcus tend to occur in contacts less than 5 years of age within the family. Secondary cases are uncommon in classroom or school contacts. Surveillance of household contacts for invasive Haemophilus disease should include exposed unimmunized or incompletely immunized children.
Immunization	Infants should receive Haemophilus influenzae (Hib) vaccine according to the recommended schedule. Meningococcal vaccine may be recommended for community or school outbreaks.
Public Health Action	Report cases immediately to the Department of Health; the Epidemiology Office will coordinate contact assessment and implementation for antibiotic prophylaxis and surveillance.

School Action	<ul style="list-style-type: none"> ▪ Refer students with suspected meningitis for emergency medical care. ▪ Report suspected cases to the Department of Health. ▪ Assist the Department of Health in identification and prophylaxis of contacts as well as communication with parents and staff. ▪ Provide prevention education. ▪ Offer vaccine to all unimmunized staff and students. ▪ Exclude infected students until a release to return is provided by the primary care provider.
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Conditions, Disease, Agent	<u>MENINGITIS (VIRAL or ASEPTIC)</u> Enteroviruses (ECHO and Coxsackie), other viruses
Clinical Description	Symptoms include fever, headache, stiff neck, myalgia and vomiting. Many enteroviral infections produce other symptoms including fever, flu-like illness, gastrointestinal or respiratory symptoms or rash. Although enteroviral infections can occur year-round, they are most common in summer and early fall. Seizures, coma and neurologic complications can occur.
Transmission, Exposure	Direct person-to-person through droplet spread of or contact with secretions; fecal-oral for many enteroviruses.
Contagious Period	Enteroviruses can be recovered for weeks to months after infection, depending on the virus that is causing the meningitis.
Incubation	3-6 days for enteroviruses.
Diagnosis	Examination of spinal fluid and spinal fluid culture can help to confirm clinical diagnosis.
Management of Case	There is no specific treatment. Supportive treatment is provided as indicated by the specific clinical indications. When the child has recovered, he/she may return to school without limitations according to primary care provider's recommendations.
Management of Contacts	Other cases of enteroviral infection are likely to occur in the same school or other group, but it is not likely that there will be other cases of meningitis or other serious illness. Contacts with symptoms suggestive of meningitis should be referred for medical evaluation.
Public Health Action	No specific reporting of cases of viral meningitis required.

School Action	<ul style="list-style-type: none"> ▪ Refer suspected students for medical evaluation. ▪ School exclusion is not necessary unless prescribed by medical provider.
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Condition, Disease, Agent	<u>MONONUCLEOSIS (INFECTIOUS MONONUCLEOSIS, MONO)</u> Epstein-Barr virus (EBV)
Clinical Description	Persons with "mono" usually have fever, sore throat which may be severe, splenomegaly and enlargement of lymph nodes. Malaise and fatigue may be severe and prolonged. Mild hepatitis is the rule, but jaundice is uncommon. Symptoms may return after a period of convalescence. Children infected during adolescence or young adulthood tend to have more typical disease.
Transmission, Exposure	Direct transmission and indirect exposure through person-to-person contact with respiratory secretions and by droplets contaminating hands or objects. The virus may also be transmitted by blood transfusion.
Contagious Period	Viral shedding begins before onset of symptoms; periodic shedding occurs even after complete recovery and is probably the source of most new infections.
Incubation	30-50 days.
Diagnosis	Clinical diagnosis of typical illness is reliable. Laboratory diagnosis is by typical findings in the blood (increase in lymphocytes, with many "atypical lymphocytes"). Serologic tests (e.g. Monospot) are usually positive by the second week of illness.
Management of Case	Because of a small risk of rupture of the enlarged spleen, infected children should be excluded from contact sports until the spleen has returned to normal size. There is no specific treatment for "mono". Children who are well enough to attend school should not be excluded.
Management of Contacts	Because the virus is present in saliva, hand washing and washing of objects contaminated with saliva should reduce transmission from person to person.
Public Health Action	EBV infections are not reportable.

School Action	<ul style="list-style-type: none"> ▪ Refer children with suspected infectious mononucleosis for medical evaluation. ▪ School exclusion is not appropriate unless student is unable to participate in routine activities. The student's physician should determine when the student can return to school and to athletics ▪ Provide prevention education.
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Condition, Disease, Agent	<u>MUMPS</u> Mumps virus, RNA virus
Clinical Description	Mumps is an acute viral infection. Most cases include fever, typical enlargement of the salivary glands. Rarely, pancreatitis, orchitis in males, oophoritis in females, and encephalitis may occur. Complications are more common in adults.
Transmission, Exposure	Direct respiratory droplets or other contact with respiratory secretions and saliva.
Contagious Period	6-7 days before until 9 days after swelling begins.
Incubation	16-18 days with a range of 12-26 days.
Diagnosis	Virus isolation and serology including detection of IgM antibody are recommended. Clinical diagnosis of symptomatic mumps is reliable in outbreaks. Isolated cases of salivary gland swelling may be caused by other viruses, blockage of a salivary duct or bacterial infection. Confirmation of the disease is important before extensive surveillance or immunization is undertaken.
Management of Case	Refer students with possible mumps for medical evaluation. There is no specific treatment; most children are only mildly ill. School exclusion: 9 days after onset of swelling.
Management of Contacts	Contacts of mumps cases who have not had two doses of mumps vaccine should be immunized preferably with MMR vaccine. Adult contacts with no prior history of mumps illness or immunization should be considered for mumps vaccine. Testing to determine susceptibility should be considered before vaccination with MMR since a majority of adults without a history of mumps will be immune. because of subclinical or unrecognized infection. Mumps in adults is more likely to be severe with systemic involvement.
Immunization	All children should receive one dose of MMR vaccine before school entry and a second dose at 11 years of age; adolescents who have not received a second dose should receive a booster.
Public Health Action	Report possible cases to the Department of Health.

School Action	<ul style="list-style-type: none"> ▪ Refer students with enlarged salivary glands for medical evaluation. ▪ Exclude students with confirmed mumps for 9 days following onset of swelling. ▪ Exclude unimmunized susceptible persons until 26 days after onset of swelling in the last contact case. ▪ Provide prevention education.
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Condition, Disease, Agent	<u>PEDICULOSIS (HEAD LICE)</u> <u>Pediculus humanus capitis</u> , parasitic arthropod
Clinical Description	Infestation of head lice occurs in hair, eyebrows and eyelashes. Itching is the most common symptom of head lice. Itching of the nape of the neck and behind the ears is common; however, itching may be totally absent. Itching following treatment may be due to treatment and not re-infestation. The most common method of detecting lice is searching the hairline and the nape of the neck for the nits.
Transmission	Lice are directly transferred through close personal head-to-head contact. Indirect contact through hats, scarfs, coats, hairbrushes and bedding can transmit the lice.
Contagious Period	Can be spread while viable adult lice and nits are present, after nits hatch.
Incubation	Eggs hatch in 6-10 days and reach maturity in 2-3 weeks.
Diagnosis	Proper diagnosis of head lice is the most important step in controlling the infestation. To identify adult lice or viable eggs, a good light and fine toothed comb are needed. Starting at the nape, systematically comb through hair. After each passage of the comb, tap it on a clean paper towel and observe for moving forms. Making diagnosis on nits alone has a high proportion of false positives. There are desquamated epithelial cells (such as pseudonits or hair muffs) that encircle the hair shaft and may be easily removed in contrast to true nits which are smaller, silvery-white, shaped like tiny teardrops and adhere firmly and eccentrically to hair shaft. Most persons with head louse infestation will have between 10 and 20 lice.
Management of Case	<p>After proper diagnosis, the most critical step in control of lice is proper treatment. Both permethrin and pyrethrins containing products (OTCs) are usually successful in treating infestations <u>if used properly</u>. <u>Education in the proper use of products should follow specific manufacturers' recommendations</u>. Treatment is repeated in 7-10 days to kill those lice not yet hatched. Most treatment failure is due to improper use of products and not treatment resistance. Proper treatment includes examination of all household members for lice and treatment of all infested members. Product treatment should not be used prophylactically in the non-infested. After treatment a fine-toothed comb should be used to remove nits; however, no one should be excluded from school based solely on presence of nits. Clothing and headgear of the infected should be laundered in hot soapy water and dried in a dryer to kill lice and nits. Items that cannot be cleaned in this manner (such as wool caps, hair brushes) should be sealed in a plastic bag for 14 days since nits cannot hatch in these conditions and lice cannot survive off the human body longer than 2 days. Effective shampoo treatments are available without prescription (permethrin 1% and pyrethrins). Lindane 1% by prescription should be used only for treatment failures.</p> <p>Children when diagnosed with head lice should be excluded from school at the end of the day until at least one treatment has been administered. Those with nits only after treatment need not be excluded but followed up for repeat treatment.</p>
Management of Contacts	Examination of the hair will determine if other children are infested. When one case of head lice is found in a school room, examination of all other students is appropriate for proper surveillance.
Public Health Action	Pediculosis is not a reportable condition.
School Action	<ul style="list-style-type: none"> ▪ Exclude infested students at the end of the school day until they have received treatment. ▪ Examine contacts and others in classroom for infestation. ▪ Provide educational material including treatment recommendations to parents and recommend laundering bedding and clothes. ▪ Provide prevention education for students and staff. ▪ Recommend that children not share headgear or hairbrushes.

Condition, Disease, Agent	<u>PERTUSSIS (WHOOPING COUGH)</u> Bordetella pertussis, Bordetella parapertussis
Clinical Description	Pertussis has three stages: the catarrhal stage with sore throat, coryza, mild cough and low grade or no fever lasts 7-10 days; the paroxysmal stage with increasingly severe spasms of cough with post-tussive whoop or vomiting lasting one to three months; and the convalescent stage with gradual lessening of coughing spasms. Infants under six months of age may have apnea and no whoop. Immunized children and adults may have mild symptoms resembling an ordinary upper respiratory infection.
Transmission, Exposure	Direct person-to-person by respiratory droplets.
Contagious Period	Onset of symptoms until 3 weeks of cough; period of maximal contagiousness is the first two weeks of cough.
Incubation	7-10 days with range of 6-20 days.
Diagnosis	Laboratory diagnosis is by culture and direct staining of nasopharyngeal secretions. Mild cases may be difficult to recognize unless they occur in contacts of typical disease.
Management of Case	Refer persons with severe or persistent cough for medical evaluation. The cough may persist for weeks or months even after appropriate treatment. Students may need restriction of activity if they have exercise-induced spasms of coughing. Exclude probable or confirmed cases until after five days of antibiotic treatment .
Management of Contacts	Identify close contacts and refer them for preventive treatment. Children under seven years of age should receive a pertussis vaccine booster if it has been more than three years since the previous dose.
Immunization	Infants and children should receive DtaP according to recommended schedule. Protection against infection wanes steadily after the last dose (currently given before age seven) so many school age children and adults are susceptible.
Public Health Action	Report suspected or confirmed cases to the Department of Health. The Epidemiology Office will coordinate testing, contact identification and treatment.

School Action	<ul style="list-style-type: none"> ▪ Refer suspected cases for medical evaluation and treatment. Immediately. ▪ Report confirmed and possible cases and clusters of possible pertussis to the Department of Health. ▪ Exclude cases until after five days of antibiotic treatment (three weeks after onset of cough if not treated). ▪ Review immunization records to identify unimmunized contacts. ▪ Provide prevention education.
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Condition, Disease, Agent	<u>PLAGUE</u> Yersinia pestis (bacteria)
Clinical Description	<p>Bubonic plague: The primary site of inoculation may resemble an infected insect bite or the site may be inapparent. The regional lymph nodes become enlarged and exquisitely tender (bubo). Most patients have fever and non-specific flu-like symptoms (vomiting, diarrhea). Untreated patients with bubonic plague may develop (secondary) bacteremia.</p> <p>Septicemic plague: High fever with malaise and other non-specific symptoms occur, but no bubo is present to clinically distinguish symptoms from sepsis due to other agents.</p> <p>Pneumonic plague: This condition may develop following bacteremia with cough and the production of bloody sputum.</p> <p>Complications of plague include endotoxic shock with respiratory failure, disseminated intra-vascular coagulation, meningitis, osteomyelitis and other foci of bacteremic dissemination may occur. Even with appropriate antibiotic and supportive therapy, the mortality rate in advanced plague is very high.</p>
Transmission, Exposure	Humans are infected by: (1) bite from a plague infected flea, (2) bite or contact with respiratory secretions from a person or animal, often a domestic animal that has pneumonic plague, (3) contact with tissues from an infected animal such as a rodent, rabbit or coyote.
Contagious Period	For pneumonic plague: from the time the patient begins to cough until the patient has completed several days of antibiotic therapy. Bubonic and septicemic plague usually are not contagious.
Incubation	2-8 days for bubonic plague; 1-4 days for human-to-human transmission of pneumonic plague.
Diagnosis	Plague may resemble wound infections with secondary lymphadenitis. Cultures should be obtained from blood and apparent sites of infection (such as the affected lymph node).
Management of Case	Possible cases must be referred immediately for medical evaluation and treatment.
Management of Contacts	Contacts of pneumonic plague cases should be given antibiotic prophylaxis immediately and be kept under surveillance for development of illness. Close contacts of all plague patients may have had the same environmental exposure.
Prevention Education	Reduce rodent activity near homes and schools. Protects domestic animals from fleas. Children should avoid contact with animals, especially if they appear ill.
Public Health Action	Report cases of suspected plague immediately to the Department of Health.
School Action	<ul style="list-style-type: none"> ▪ Refer possible cases immediately for medical evaluation. ▪ Assist in identifying close contacts; contacts need not be excluded from school unless they are ill. ▪ Report rodent activity (especially prairie dogs and ground or rock squirrels) on or near school grounds to the Department of Health (Vector Control Program); report unusual numbers of dead rodents to the Department of Health promptly.

Condition, Disease, Agent	<u>RUBELLA (GERMAN MEASLES, THREE-DAY MEASLES)</u> Rubella virus
Clinical Description	A diffuse maculopapular rash is often the first sign of illness; however, a mild prodromal illness, with low-grade fever, malaise, and headache may occur 1-4 days before the rash appears. The rash appears first on the face but spreads rapidly over the entire body. The rash consists of small, flat (not palpable), reddish-pink spots, and rarely lasts more than 3 days. Adolescents and adults with rubella may have arthritis affecting a few joints lasting a few days or weeks. Congenital rubella varies in severity from subclinical to combinations of microcephaly, mental retardation, cataracts, deafness, and heart defects.
Transmission, Exposure	Droplet or contact transmission by respiratory secretions or urine. The virus crosses the placenta and infects the fetus if a pregnant woman is infected.
Contagious period	A few days before the rash develops to 5 to 7 days after the rash begins. Children with congenital rubella may shed virus in their urine for 1 year or longer after birth.
Incubation	Usually 14 to 17 days with range of 14- 21
Diagnosis	Presence of a typical rash and tender lymph nodes at the base of the skull or behind the ears suggests the diagnosis of rubella although other viral infections can produce a similar syndrome. Confirmation by serology is essential. Virtually all patients will have specific rubella IgM antibody during the acute illness. Confirmation of acute infection may require paired sera. MMR immunization status should be established.
Management of Case	All persons with rubella-like illness should be referred immediately for medical evaluation. There is no specific treatment. School exclusion: While the patient has been contagious for several days before they became ill and may have transmitted infection to susceptible contacts already, the infectious period continues for 5-7 days. Therefore, the patient should be excluded for a period of 7 days.
Management of Contacts	Contacts who are known to be susceptible should be immunized immediately. Adult contacts may be tested for immunity if test results will be available within 24 hours (so that immunization will not be delayed). Pregnant women should contact their obstetrician immediately to determine their immune status.
Immunization	Rubella vaccine should be given to all infants at 12-15 months of age. Booster vaccination should be given after the fourth birthday. Pregnant women should not be vaccinated (see above) and all women over age 12 should be counseled to avoid pregnancy for 3 months after immunization.
Public Health Action	Report all cases of suspected or confirmed rubella to the Department of Health. Identification and immunization of susceptible contacts will be coordinated by the Office of Epidemiology.

School Action	<ul style="list-style-type: none"> ▪ Refer all possible cases for medical evaluation. ▪ Exclude the case from school until seven days after onset of rash. ▪ Enforce immunization of all students with 2 doses of MMR vaccine before school entry; the second dose should be given after the fourth birthday. ▪ Report suspected and confirmed cases to the Department of Health.
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Condition, Disease, Agent	<u>RUBEOLA (MEASLES)</u> Rubeola virus
Clinical Description	Acute onset of fever coryza, non-exudative conjunctivitis, cough and rash which usually begins on the second or third day of illness characterizes rubeola. The rash begins on the face or neck under the hairline or behind the ears and progresses to the trunk and extremities over 1-2 days. The rash is red, maculopapular with some clustering which tends to become confluent on the face. Koplik's spots are present inside the mouth. Potential complications include otitis media, pneumonia, croup, diarrhea and encephalitis. Immune-impaired children and adults usually have more severe illness and a higher risk of death.
Transmission, Exposure	Droplet and airborne transmission of respiratory secretions. The virus may circulate in the air up to four 4 after the patient leaves a room.
Contagious Period	1-2 days before onset of symptoms (3-5 days before onset of rash) until 4 days after appearance of rash.
Incubation	Average of 14 days from exposure to onset of rash with a range of 7-18 days or 8-12 days from exposure to onset of symptoms.
Diagnosis	Presence of IgM antibody in a person who has not been immunized recently is diagnostic. Virus can be cultured from respiratory secretions.
Management of Case	Refer possible cases immediately for medical evaluation. There is no specific treatment. School exclusion: until four days after rash onset.
Management of Contacts	Review immunization records to determine whether susceptible students or staff who have not had two doses of measles vaccine documented after the first birthday or other evidence of measles immunity are present in the school. Give susceptible contacts vaccine within 72 hours of exposure; give immune globulin to susceptible contacts who should not receive vaccine, including pregnant women and those who refuse. Exclude susceptible contacts from school until 21 days after rash onset in the last case unless they receive a dose of measles vaccine within three days of exposure. Susceptible individuals who were given post-exposure preventive treatment with immune globulin should be excluded until 28 days after rash onset in the last case.
Immunization	Immunity rate of 95-98% is required to prevent sustained transmission of measles in a community; all children are required to have two doses of vaccine before school entry.
Public Health Action	Report all possible cases to the Department of Health immediately.

School Action	<ul style="list-style-type: none"> ▪ Refer possible cases immediately for medical evaluation. ▪ Report confirmed and suspected cases to the Department of Health. ▪ Exclude cases from school until 4 days after onset of rash. ▪ Review immunization records to identify susceptible individuals. ▪ Exclude unimmunized, susceptible individuals until 21 days after onset of rash in the last case.
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Condition, Disease, Agent	<u>SCABIES</u> Sarcoptes scabiei (ecto-parasite)
Clinical Description	The scabies mite invades the outer layer of skin and feeds on tissue fluids. The female mite creates a linear burrow on finger webs, skin folds and around the ears in which she deposits eggs. Mite infestation does not cause symptoms until an immune response to the mite develops after 4-6 weeks. Intense itching of the burrows and entrance/exit sites causes scratching especially at night. Excoriation of the skin may be complicated by bacterial superinfection.
Transmission, Exposure	Usually by direct contact from person-to-person. It can survive only a short time off the body. Mites that infest other animals usually do not infest humans.
Contagious Period	Until the infestation is treated.
Incubation	4-6 weeks from exposure to symptoms for the initial infestation; 1-4 days after re-exposure since immunity already exists.
Diagnosis	Exam shows typical excoriated papules and burrows. Microscopic exam of skin scrapings shows the mite, eggs, and fecal deposits.
Management of Case	Request parents to complete treatment before returning the student to school. Specific treatment: some scabicides are available without prescription including permethrin; lindane (Kwell) is an alternative if retreatment is necessary but it is more toxic. Clothing and bedding should be laundered in hot water although they are not usually responsible for transmission of the mite.
Management of Contacts	Close contacts should be examined for signs of infestation. Household contacts are usually infested and need treatment.
Public Health Action	Scabies is not a reportable condition. The local Health Office can assist families with treatment.

School Action	<ul style="list-style-type: none"> ▪ Exclude infested students at the end of the school day until they have received treatment. ▪ Examine contacts and others in classroom for infestation. ▪ Provide educational material including treatment recommendations to parents.
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Condition, Disease, Agent	<u>STREPTOCOCCAL INFECTIONS (STREPTHROAT)/SCARLET FEVER</u> Streptococcus pyogenes (Group A)(GAS)
Clinical Description	Classic strep throat is characterized by more/less severe sore throat, malaise, toxicity, fever, tender lymph nodes in the neck, and a purulent exudate on the tonsils. Untreated strep throat develops complications including otitis media, sinusitis, and abscesses on the tonsils and pharynx. Scarlet fever is a strep throat plus a characteristic fine, sand-papery erythema rash prominent on the cheeks, trunk and extremities with sparing around the mouth, inside elbows and behind knees. Invasive streptococcal infections may follow wound infections including infected varicella lesions or respiratory infections.
Transmission, Exposure	GAS is transmitted person-to-person mainly via respiratory secretions. Outbreaks of strep throat may occur from food or milk contamination. Carriers may serve as reservoirs for re-colonization of individuals with recurrent streptococcal disease.
Contagious Period	Asymptomatic carriers may remain culture-positive and presumably contagious for weeks to months. After acute illness, shedding of bacteria continues for 10-21 days or 24 hours after treatment.
Incubation	2 to 5 days for pharyngitis
Diagnosis	Rapid strep test from throat swab or throat culture
Management of Case	Refer possible cases of strep throat for medical evaluation. Referral is urgent if high fever, marked toxicity, respiratory distress, marked swelling or pain of a skin infection is present. School exclusion is suggested until at least 24 hours of antibiotic treatment is completed.
Management of Contacts	For sporadic cases of uncomplicated streptococcal infection, surveillance for additional cases is adequate.
Public Health Action	Report cases of scarlet fever, streptococcal toxic shock syndrome or invasive streptococcal disease and outbreaks of streptococcal disease within schools to Department of Health.
School Action	<ul style="list-style-type: none"> ▪ Refer potential cases for medical evaluation and treatment. ▪ Exclude cases until the infected individual has been on antibiotic treatment for at least 24 hours. ▪ Report complicated cases and outbreaks of streptococcal infection to the Department of Health.

Condition, Disease, Agent	<u>TINEA CAPITIS, CORPORIS, CRURIS and PEDIS</u> (Ringworm of scalp, body, groin and feet) Fungi of the genera <u>Microsporum</u> and <u>Trichophyton</u> .
Clinical Description	Frequently itchy patches and ring-shaped lesions on the scalp or skin of the trunk or extremities; lesions are usually reddish, scaly, crusted at the margins with central clearing. Fissuring may occur in skin folds. Balding patches may occur on the scalp; the hairs are broken off near the skin or scalp rather than completely absent. Especially if bacterial infection develops because of scratching, lesions may become inflamed with a bloody, purulent discharge.
Transmission, Exposure	Direct or indirect contact with skin and scalp lesions of infected persons or animals, as well as contact with contaminated clothing, hats, showers, towels, benches and sports equipment.
Contagious Period	As long as fungi can be cultured or seen by microscopy; fungi may remain viable on surfaces indefinitely.
Incubation	Unknown, usually several days to weeks.
Diagnosis	Depending on the fungus, lesions may show fluorescence by Wood's light (ultraviolet light) examination: bright (microsporum) and dull green (trichophyton). Diagnosis is confirmed by microscopic examination of scrapings from the edge of a lesion placed in 10% potassium hydroxide solution or by culture of the fungus.
Management of Case	Refer possible cases for medical evaluation and treatment. School exclusion is not necessary especially if skin (not scalp) lesions can be covered by clothing or a loose dressing until treatment has been initiated.
Management of Contacts	Examine close contacts including household pets by visual examination of the skin and scalp.
Public Health Action	Ringworm is not a reportable condition

School Action	<ul style="list-style-type: none"> ▪ Request parent to initiate treatment for tinea corporis; refer possible cases of tinea capitis for medical evaluation and treatment. ▪ School exclusion is usually not necessary. ▪ Observe contacts for development of lesions. ▪ Require disinfection of appropriate sports equipment..
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Condition, Disease, Agent	<u>TUBERCULOSIS</u> Mycobacterium tuberculosis (B)
Clinical Description	Primary infection in children may produce non-specific symptoms of fever, weight loss and cough. Reactivation of infection in adolescents or adults produces an enlarging cavity in the lung containing large numbers of bacteria. Active pulmonary tuberculosis causes chronic cough with purulent, often blood tinged sputum. Chest pain may be present especially if the pleura is involved. Systemic symptoms are common including fatigue, weight loss, night sweats and fever which is usually maximal in the late afternoon and evening. Other manifestations may include infection of meninges, bone/joint, kidney, genital tract, peritoneum, skin or lymph nodes.
Transmission, Exposure	Infectious droplet nuclei (dried droplets of respiratory secretions) shed by a patient with an active lung infection and breathed in by a susceptible contact. Usually, transmission requires close contact over a period of time. The number of bacteria present in secretions, the efficiency of coughing, closeness of contact, and size of the airspace containing the infected droplet nuclei influence the risk of transmission to contacts.
Incubation	2-12 weeks from exposure to development of a positive tuberculin test; clinical disease is most likely to occur within the first 2-3 years after infection but may occur decades later.
Contagious Period	Throughout period of active infection until 1-3 weeks after initiation of effective treatment.
Diagnosis	Clinical diagnosis on the basis of physical examination may be suggestive of tuberculosis, especially if the child is known to have been exposed. A positive tuberculin skin test means that the person has been infected with M. tuberculosis or has received BCG vaccine but does not necessarily indicate that the infection is active. Laboratory diagnosis made by microscopic examination and culture of sputum or other specimens is important to confirm the diagnosis and select appropriate antimicrobial treatment.
Management of Case	Refer students and staff with persistent cough (longer than three weeks) or other symptoms of possible tuberculosis for medical evaluation. Completion of treatment is critical to prevent relapse and development of secondary drug resistance. The Tuberculosis Control Program will clear a child to return to school who is physically able and has been on treatment for at least two weeks and when the cough (if present) is subsiding.
Management of Contacts	The Tuberculosis Control Program will coordinate tuberculin testing, and determine the need for chest x-ray, physician evaluation, preventive treatment, and treatment of contacts.
Vaccine	BCG vaccine is given in parts of the world where there is risk of childhood tuberculosis, but it is not utilized in the United States.
Public Health Action	All active cases of tuberculosis should be reported to the Department of Health. Children who are positive tuberculin reactors should be referred also since infection in a child indicates recent exposure to an active case. The Tuberculosis Control Program will coordinate contact evaluation.

School Action	<ul style="list-style-type: none"> ▪ Refer children and staff with a chronic cough (longer than three weeks) or other symptoms of possible tuberculosis for medical evaluation. ▪ Report possible or confirmed cases to the Department of Health. ▪ Exclude students and staff with active tuberculosis from school until determined by the Tuberculosis Control Program to be non-contagious.
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Condition, Disease, Agent	<u>VAGINITIS</u> Trichomoniasis, Candidiasis
Clinical Description	Thick white (Candida) or malodorous gray (Trichomona) vaginal discharge, often with external irritation that usually includes itching or dysuria.
Transmission, Exposure	Transmission occurs through genital contact and is also transmissible by contaminated articles.
Incubation	May be indeterminate
Contagious Period	May be indefinite or several years in untreated persons
Diagnosis	Usually made by microscopic examination of the infecting agent from vaginal discharge.
Management of Case	Specific treatment depends on the cause. Sexual contact should be avoided during period of infection and treatment of patient and partner.
Management of Contacts	Sexual partners are usually asymptomatic, but they should be evaluated and treated.
Public Health Action	Promotion of "safer sex" behavior, including condom use, for all nonmutually monogamous sexual contacts is indicated.

School Action	<ul style="list-style-type: none"> ▪ Offer preventive education with sex education curriculum. ▪ Refer potential cases for non-emergency evaluation and appropriate treatment. ▪ School exclusion not appropriate.
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