SECTION X:
COMMUNICABLE DISEASE CONTROL

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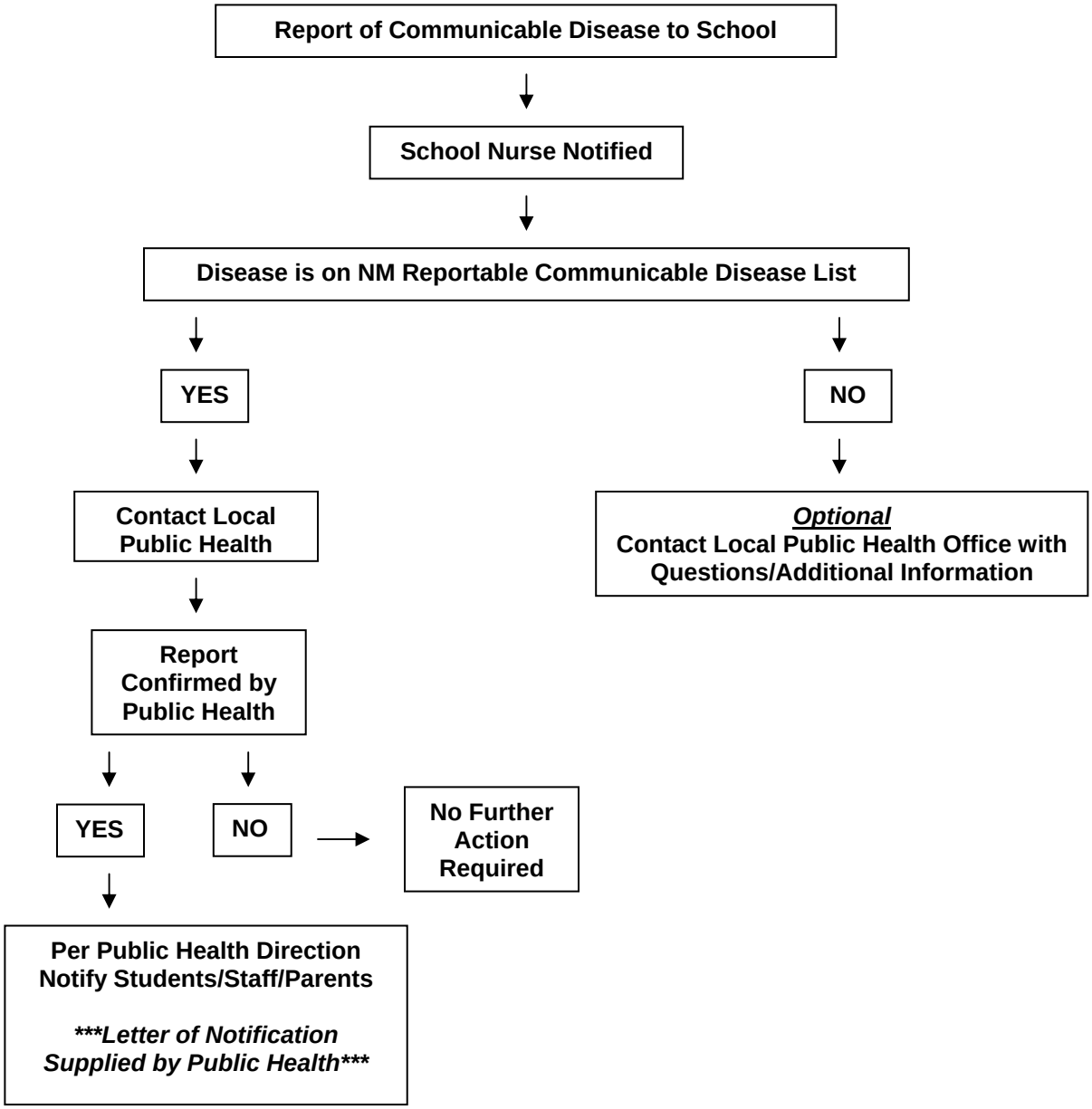
NOTIFIABLE CONDITIONS IN NEW MEXICO

http://www.health.state.nm.us/epi/NotifiableConditions_Final_063006.pdf

REPORTABLE COMMUNICABLE DISEASE FOLLOW-UP ALGORITHM AND NEW MEXICO DEPARTMENT OF HEALTH CONTACT LIST



NEW MEXICO DEPARTMENT OF HEALTH CONTACT LIST

State Epidemiologist: (505) 827-0006

NM District Health Officers: (505) 841-4100 Albuquerque (505) 476-2600 Santa Fe
(575) 528-5137 Las Cruces (575) 347-2409 Roswell

Local Public Health Office: _____

PUBLIC HEALTH EMERGENCY HOTLINE: (505) 827- 0006

Infectious diseases occur frequently in the school setting. Factors that affect the risk of disease in schools include age of students, immunity of the group, number of students, the degree of close contact between children and providers, and the hygienic habits of students and staff.

Medical events with community wide consequences occur hundreds of times each year in New Mexico, some in the school setting. Cost effective care can take on a whole new meaning when a single case of certain diseases translates into many, with scores of contacts needing screening, protection and surveillance. In such cases, there are substantial resources available twenty-four hours a day, seven days a week through the Epidemiology and Response Division of New Mexico Department of Health. This office provides expert consultation through a telephone hotline linked to health professionals experienced in management and control of outbreaks as well as laboratory assistance in making diagnoses and obtaining vaccines and/or prophylactic medications.

This system is not merely a convenience; it is required by New Mexico statute and administrative code. As a part of this system, physician offices, laboratories, and other health care agencies are required to report suspected or actual cases of notifiable diseases to the Epidemiology and Response Division. A list of notifiable diseases can be found at **http://www.health.state.nm.us/epi/NotifiableConditions_Final_063006.pdf .**

Under the same statutes and rules, the Office of Epidemiology is required to identify and control outbreaks of these diseases and to report this information to the Centers for Disease Control and Prevention as a part of national data collection. It is reports from health care providers to the Epidemiology and Response Division that are forwarded to the CDC as New Mexico data.

To report a notifiable disease, receive expert consultation and support during a potential outbreak or to speak with an epidemiologist call (505) 827-0006. *Manual for Investigation and Control of Communicable Diseases in New Mexico* can be found at the following web site: **http://www.health.state.nm.us/epi/CDManualFinal04.pdf**

PROCEDURES FOR CONTROL OF COMMUNICABLE DISEASES

CLASSROOM CLEANLINESS

Definition: Maintaining cleanliness to prevent the transmission of communicable diseases in the classroom.

Guidelines:

- Adequate hand washing facilities should be available to students and staff. This includes a sink, hot and cold running water, liquid soap, and disposable paper towels. See http://www.health.state.nm.us/epi/#handwashing .
- Separate storage areas for clean clothing and linens apart from soiled clothing and linens should be provided.
- All soiled disposable items should be held in waste receptacles lined with plastic bags which should discarded by staff twice daily. **THESE PLASTIC BAGS SHOULD NEVER BE RE-USED!** Contaminated items, including disposable diapers, discarded in an uncovered waste receptacle should be placed in a separate small plastic bag before being discarded.
- Approved bactericidal solutions should be used to clean toys, tables, chairs and other environmental surfaces. A solution of 1:9 bleach may be used (one part household bleach to nine parts water), but it must be mixed fresh weekly if stored in opaque container or daily if in clear container to maintain efficacy. All disinfectants should be properly labeled and stored safely out of reach of students.
- Only washable toys should be available in the classroom.
- All equipment, toys, tables, chairs, mats, therapy equipment, etc., used by students who drool or mouth them should be washed with appropriate disinfectant at the end of each day or before use by another student. The use of non-washable furniture and equipment in the classroom is **STRONGLY DISCOURAGED**.
- Wheelchairs and trays must be washed with soap and water after feeding. If students eat in the classroom, all soiled tables and chairs should be cleaned.
- Physical or occupational therapists should be contacted before cleaning orthopedic equipment such as braces, splints, etc., to be sure disinfectant choice is appropriate.
- The sink area should be cleaned with disinfectant at the end of each day. **NEVER** scrape food into sink or rinse soiled dishes in sink. Food should be returned to the school cafeteria or scraped into plastic bags and discarded into a waste receptacle. All eating utensils and equipment should be washed in a dishwasher. They should be collected in a suitable container that can also be washed and taken to the kitchen as soon as possible. Clean dishes should be transported back to the classroom in a container that has also been washed.
- Adaptive feeding equipment and other non-disposable dishes should be kept in a clean storage area.
- Students' personal grooming items should be kept in separate containers.
- Soiled rugs or carpet should be cleaned immediately and not be used until the area is dry. Students who are unable to control body fluids should **NEVER** be placed directly on a carpet/rug but should be placed on a washable mat or blanket. Diapering should **NEVER** be done on carpet or a rug.

- Changing tables, portable potties and toilet seats should be nonporous and be cleaned with approved disinfectant after each use. Portable potties should be emptied into the toilet and disinfected after each use.
- All toilets, potties (both seats and bowls), sinks, diaper changing tables and floor around changing mat should be disinfected daily. Tile areas of classroom floor should be wet mopped with disinfectant daily in classrooms where students eat and when floor becomes soiled with body fluids. Routine carpet care/shampooing should be provided as needed but not less than twice a year.

CLASSROOM COOKING

Definition: Preparing food for the purpose of teaching students skills, reinforcing learning or meeting other educational goals.

Guidelines:

- Before use in classroom cooking, tables and work areas should be cleaned with an approved disinfectant such as a fresh solution of 1 part chlorine bleach to 10 parts water. (If an opaque container is used, the solution needs to be changed weekly; if a clear container is used, the solution must be changed daily to maintain efficacy.)
- Students and instructional personnel should wash hands with soap and water before and after handling food. This process must be repeated any time a student leaves the activity or puts hands to mouth, nose or perineal area.
- Students who have symptoms of illness, or who drool excessively should be excluded from the cooking activity.
- It is recommended that disposable scoops, spoons, tongs and gloves for handling food be used as often as possible and that disposable dishes and dinnerware be used for serving food.
- Students should not be allowed to use fingers to taste food from the preparation bowls.
- Leftovers should be properly stored or disposed and not left out in the classroom or in the trash can overnight. Food should not be disposed of nor should dishes be rinsed in a classroom sink, unless the sink is equipped with a garbage disposal.
- Any non-disposable dishes, pans, utensils and adaptive equipment should be washed in a dishwasher or in the school cafeteria or kitchen.
- Tables and work surfaces used in any cooking activity should be cleaned as in step one above. All individuals participating in the cooking activity should wash hands as in step two.

DIAPERING

Definition: Changing diapers in such a way so that potential for communicable disease transmission is decreased.

Guidelines:

- Students who are not toilet trained should be checked at least every 2-3 hours and changed when soiled.

- Assemble the following equipment.
  - Wet disposable towelettes
  - Dry disposable towels/pads
  - Disposable diapers
  - Covered waste receptacle lined with plastic bag
  - Small plastic bag for disposing of diapers if they contain feces or blood
  - Disposable gloves
  - Washable changing table
  - Disinfectant for cleaning changing table
- Place student on changing table with a nonporous surface in bathroom or other appropriate setting. Diapers should **NEVER** be changed in the classroom. **A STUDENT SHOULD NEVER BE LEFT UNATTENDED ON THE CHANGING TABLE.**
- Place disposable pad, towel, or paper under student's buttocks. Remove clothing or lift up as necessary to assure all clothing is above the area of the naval.
- Use disposable gloves according to universal precautions.
- Remove diaper and discard directly into waste receptacle or plastic bag. **NEVER** place a soiled diaper on the floor, carpet or furniture.
- Wash perineal area with disposable towelette. In girls, wash from top to bottom and discard towel after each stroke to prevent organisms from entering the vaginal or bladder area. Dispose of towelette with diaper. Place clean diaper on student.
- Remove dry towel from under student. Remove disposable gloves. Discard into waste receptacle.
- Wash student's hands before returning him/her to class.
- Wash changing table with disinfectant.
- Wash hands according to hand washing procedure described in this section.

HANDWASHING

Definition: The single most effective technique in preventing transmission of infectious diseases due to individuals carrying or incubating disease without symptoms.

Guidelines:

- Access to adequate hand washing facilities is necessary, including a sink, hot and cold running water, liquid soap and disposable towels.
- Hands should be washed with soap:
  - Before eating and drinking
  - Before handling dining equipment or utensils
  - Before and after handling any food
  - Before and after assisting in toileting, diapering or feeding
  - After contact with body fluids or blood
- It is recommended that rings and bracelets be removed before hand washing, because microorganisms can become lodged in jewelry settings.
- Recommended procedures for hand washing include the following.
  - Wet hands with warm, running water and apply liquid soap. Warm water helps to get the organisms, dirt and debris into suspension and running water carries them away. Bar soap in a dish provides a place for bacteria to grow.
  - Wash, using a circular motion and friction, for 10 to 30 seconds. Include front and back of hands, between fingers, around nails and wrist area.
  - Hold hands so that water drains from wrist area to finger tips and rinse well under warm, running water.
  - Dry hands well with paper towels. Turn off water faucet with towel and then discard towel in wastebasket.
  - Apply lotion as desired to prevent chapping, because chapped skin breaks open easily, permitting bacteria to enter the system.
- To access songs, curriculum, posters, brochure, etc. on hand washing for use in the school setting go to **http://www.health.state.nm.us/epi/#handwashing.**

BLOODBORNE PATHOGENS EXPOSURE RISK

Definition: Potential for exposure to communicable disease through contact with contaminated/infectious blood/body fluids.

Guidelines:

- The OSHA Standard 29 CFR 1910.1030 Bloodborne Pathogens requires employers to identify the risk to employees of exposure to bloodborne pathogens in the work place. Those regulations apply to all employees who potentially might come in contact with blood or infectious materials in the scope of job duties.

- Each school district should identify a person responsible for writing and implementing an occupational exposure plan. Risk management and nursing staff may be involved in the development of an exposure plan.

- Section XVII of this Manual contains the OSHA reference guidelines, a sample school exposure plan and training material. Federal requirements can be accessed through the OSHA website at http://www.osha.gov/SLTC/bloodbornepathogens/index.html .

TOILETING

Definition: Training, monitoring and/or assisting a student with toilet needs when the student is unable to do this independently, decreasing the risk of spreading diseases through fecal oral contamination.

Guidelines:

- Assemble all equipment
  - Suitable sized and adapted toilet/portable potty
  - Toilet tissue or disposable towelettes
  - Covered, plastic lined waste receptacle
  - Disinfectant
  - Disposable gloves
  - Disposable plastic bag
  - Clean diaper if necessary
- Remove diaper or lower underpants and assist student onto toilet seat or potty. Soiled diaper should be discarded in covered waste receptacle. It is unadvisable to give the student toys during toileting or to allow the student to remain longer than 10 minutes on the toilet/potty. **THE STUDENT SHOULD NEVER BE LEFT UNATTENDED IN THE BATHROOM.**
- After toileting needs have been met, the student should be taught to wipe him/herself with tissue from front to back and discard tissue in toilet. If the perineal/rectal area is still unclean after the student's effort, the supervising adult should complete cleaning with a disposable towelette.
- Student should be re-diapered and clothing should be appropriately arranged.
- Disinfecting/rinsing of the potty/toilet seat should be performed as appropriate.
- Hand washing by both the student and supervising adult is the most effective method to remove any fecal contamination before the student is returned to class.

COMMUNICABLE DISEASES INFORMATION SHEETS

(See http://www.cdc.gov/DiseasesConditions/ for CDC Index to Diseases and Conditions and http://www.health.state.nm.us/epi/CDManualFinal04.pdf for the NM Manual of Investigation and Control of Communicable Diseases.)

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.

Several general methods of disease prevention available to schools are 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 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 Epidemiology and Response Division hotline at (505) 827-0006. 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. (See http://www.health.state.nm.us/epi/NotifiableConditions_Final_063006.pdf.)
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 ones 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 and rules 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	**Modes of Transmission** ▪ 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 **Routes of Exposure** ▪ 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	Period of time infection that the infectious agent can be passed to another person, sometimes beginning before symptoms develop and lasting until after recovery [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.]
Incubation	Period of time between exposure to an infectious agent and the onset of symptoms
Diagnosis	Method by which the cause or nature of a disease or condition is determined [Clinical diagnosis is determined by physical examination; laboratory diagnosis by lab testing.]
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	**ANIMAL or HUMAN BITE INFECTION**: Bacterial agents include *Streptococcus, Staphylococcus, Pasteurella, Bartonella* (cause of cat-scratch fever); viral agents include 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	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. 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.
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	▪ 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.

Condition, Disease, Agent	**BACTERIAL ENTERITIS** http://www.health.state.nm.us/epi/CDManualFinal04.pdf *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	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. 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.
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, Camphylobacter, 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	▪ 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, especially if there is a suspicion of food or water transmission. ▪ Frequent hand washing should be stressed with students and staff. ▪ Provide prevention education.

Condition, Disease, Agent	**CHICKEN POX (VARICELLA)** http://www.health.state.nm.us/epi/CDManualFinal04.pdf Varicella zoster virus (human *Herpesvirus* 3)
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 pox 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 and1-2 days before onset of rash until all skin lesions have crusted, usually 5-7 days.
Incubation	About 14 days (range 8-21 days).
Diagnosis	Clinical diagnosis is reliable when the presentation is typical and varicella is known to be present in the community. In vaccinated persons who develop varicella more than 42 days after vaccination, the disease is almost always mild with fewer than 50 lesions and short duration of illness.
Management of Case	Children with varicella should not be treated with aspirin since it may increase the risk of Reye 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. Symptomatic treatment used.
Management of Contacts	Refer immune-impaired susceptible contacts (leukemia, cancer, organ transplantation, immunosuppression) to their physician immediately for passive immunization with varicella-zoster immune globulin (VZIG) after exposure. Nonimmune contacts should be quarantined and excluded from school 8-21 days after exposure. If post exposure varicella-zoster immune globulin administered, quarantine through 28 days.
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. Immunization of susceptible exposed persons more than 5 days after exposure is not effective in preventing disease but will produce immunity in persons who are not infected.
Public Health Action	Report cases to the Department of Health. Encourage administration of vaccine.

School Action	▪ Students with apparent chicken pox should be excluded from school until all lesions have crusted or until six days after onset of rash. Students 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. ▪ Exclude from school susceptible exposed from 8th-21st day after exposure. ▪ Report cases to the Department of Health. ▪ Provide prevention education. ▪ Encourage immunization for the unimmunized.

Condition, Disease, Agent	**CHLAMYDIA, GONORRHEA** *Chlamydia trachomatis* (CT, bacteria-like); *Neisseria gonorrheae* (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. 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	▪ 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. ▪ Provide prevention education to include safer sex practices.

Condition, Disease, Agent	**CONJUNCTIVITIS (PINK-EYE)** http://www.health.state.nm.us/epi/CDManualFinal04.pdf Adenovirus, Enterovirus and many respiratory viruses; *Hemophilus influenza* 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	Bacterial – during course of infection; adenovirus – late in incubation period to 14 days after onset; enterovirus – at least 4 days after onset
Incubation	1-3 days for most bacterial infections; 4-12 days for adenovirus; 12-27 hours for enterovirus
Diagnosis	Diagnosis is usually be clinical evaluation. Definitive diagnosis usually requires culture of the eye drainage.
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; symptomatic treatment is used for viral disease. 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 ones eyes are the most effective defense against eye and respiratory infections. Avoid sharing towels, eye makeup and other items that may be contaminated with infectious discharges. Ensure proper disposal of contaminated materials.

School Action	▪ 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. Based on his/her clinical judgment, the school nurse may exclude a student while the disease is active. ▪ Provide prevention education.

Condition, Disease, Agent	**CYTOMEGALOVIRUS INFECTION (CMV)** 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 is the best defense, especially after using toilet, changing diapers, assisting student with toileting and contact with saliva.

School Action	▪ Emphasize personal and environmental hygiene and standard precautions. ▪ School exclusion is not appropriate. ▪ Provide prevention education.

Condition, Disease, Agent	**DIARRHEA (Acute)** http://www.health.state.nm.us/epi/CDManualFinal04.pdf Viral Diseases: Rotavirus, Norwalkvirus, Adenovoris. Coronavirus. Bacterial Agents: *Salmonella, Shigella, Campylobacter, Vibrio, Yersinia, E. coli 0157-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. Students with diarrhea should be considered for exclusion from school primarily because of hygiene issues. Those 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. Those 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	▪ 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 no 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. ▪ Provide prevention education.

Condition, Disease, Agent	**FIFTH DISEASE (ERYTHEMA INFECTIOSUM)** Human parvovirus B19 http://www.health.state.nm.us/epi/CDManualFinal04.pdf
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. 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 may be contagious for a prolonged period.
Incubation	4 to 20 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 without 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 should avoid exposure due to potential fetal risk.
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	▪ 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 for all students and school staff. ▪ Provide prevention education.

Condition, Disease, Agent	**GENITAL WARTS** 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 can 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 appropriate.
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. HPV vaccine is effective if initiated before sexual debut of student.
Public Health Action	Not reportable to Department of Health in New Mexico.

School Action	▪ School exclusion is not appropriate. ▪ Provide prevention education as part of sex education curriculum.

Condition, Disease, Agent	**GIARDIASIS, CRYPTOSPORIDIOSIS** http://www.health.state.nm.us/epi/CDManualFinal04.pdf *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 accounting for cases in campers and hikers who drink untreated wter. 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. Contaminated municipal water systems have resulted in community-wide outbreaks.
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 should be treated with repeat treatment using same drug if initial therapy fails. As long as sanitation is adequate, there is no reason to exclude a student with giardiasis or cryptosporidium from school.
Management of Contacts	Symptomatic contacts should have stool examined and be excluded from handling food. Personal hygiene habits should be monitored for adequacy.
Public Health Action	Notify the Department of Health of outbreaks. The Epidemiology and Response Division will coordinate outbreak investigation and management. In some cases, stool surveillance 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. Avoid ingesting untreated water.

School Action

- Refer suspected cases for diagnosis and treatment.
- Report outbreaks to the Department of Health.
- School exclusion is usually not necessary unless the student is unable to maintain continence of stool.
- Exclude symptomatic contacts from handling food.
- Classroom animals with diarrhea should be isolated.
- Provide prevention education.

Condition, Disease, Agent	**HAND, FOOT AND MOUTH SYNDROME** Groups A and B Coxsackieviruses http://www.health.state.nm.us/epi/CDManualFinal04.pdf
Clinical Description	This illness occurs most common in summer and fall and is usually mild. It is characterized by tiny blisters in mouth and on fingers, palms of hands, buttocks, and soles of feet lasting a little longer than a week. Common cold symptoms may be present along with vomiting and diarrhea less frequently. Mouth discomfort make it difficult to eat or drink.
Transmission, Exposure	Direct contact with respiratory secretions and by fecal-oral route
Contagious Period	Respiratory route – less than a week after symptoms appear; fecal oral route – several weeks after symptoms appear
Incubation	3-6 days
Diagnosis	Usually clinical diagnosis is sufficient; however, coxcackievirus can be identified by culture.
Management of Case	Ill students unable to perform usual activities at school should not be at school, especially is diarrhea is uncontrolled. Hydration should be encouraged in spite of discomfort in the mouth. School staff should be alerted to watch for symptoms in other students. Hand washing and appropriate disposal of contaminated articles are important in disease control in the school setting.
Management of Contacts	Encouraging good hygiene is the most effective management along with preventive education. Symptomatic contacts should not be handling food for consumption by others.
Public Health Action	Not notifiable
Prevention Education	Prevention education should include: covering mouth when sneezing and coughing, proper disposal of contaminated articles, good hand washing technique, adequate fluid intake, good diapering technique.

School Action

- Refer suspected cases for diagnosis and treatment.
- Report outbreaks to the Department of Health (505-827-0006).
- School exclusion is not necessary unless the student is unable to maintain continence of stool.
- Exclude symptomatic contacts and cases from handling food.
- Encourage adequate hydration.
- Provide prevention education.

Condition, Disease, Agent	**HANTAVIRUS PULMONARY SYNDROME (HPS)** RNA virus of *Bunyaviridae* family http://www.health.state.nm.us/epi/CDManualFinal04.pdf
Clinical Description	The prodromal illness consists of fever and myalgia with variable respiratory symptoms, abdominal pain, vomiting or diarrhea followed by progressive cough, shortness of breath and dizziness which reflect cardio-respiratory insufficiency.
Transmission, Exposure	Contract with aerosolized rodent feces and urine (mainly deer mice) or saliva is the presumed mode of transmission. Indoor exposures in closed, poorly ventilated homes, vehicles and outbuildings with visible rodent infestations are especially suspect.
Contagious Period	No person-to-person infections of the disease has been documented in North America.
Incubation	1-6 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 a consideration.
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 (505-827-0006).

School Action	▪ School exclusion is not appropriate. ▪ Provide prevention education.

Condition, Disease, Agent	**HEPATITIS A (Acute)** http://www.health.state.nm.us/epi/CDManualFinal04.pdf Hepatitis A virus
Clinical description	Symptoms include fever, nausea, vomiting, loss of appetite or distaste for certain foods followed in 3-10 days by dark brown urine, pale feces and jaundice (yellow discoloration of eyes, skin and mucous membranes). About 70% 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 and drinks. Persons at high risk of transmission in schools are food handlers and staff who do diapering and toileting.
Contagious Period	Latter half of incubation period through first week 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 students with jaundice for medical evaluation. Students in the active phase of illness may be too sick to attend school. Those with a clinical diagnosis of Hepatitis A should be excluded until one week after onset of jaundice or in absence of jaundice for 14 days after appearance of symptoms.
Management of Contacts	Close contacts should be given immune globulin (IG) within two weeks 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 used for post-exposure prevention for ages 12 months to 40 years; for older adults IG is favored.
Immunization	One dose of Hepatitis A vaccine is required for child care enrollment at 16 months and older in New Mexico and is recommended for all children in high incidence communities. It can be given to children 12 months of age or older. Hepatitis A vaccine may also be recommended to school populations when one or more students have acute Hepatitis A disease.
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 students 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. Use standard precautions for blood borne pathogens.

School Action	▪ Refer jaundiced students 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. ▪ Exclude confirmed cases from food handling. ▪ Provide prevention education. ▪ Use standard precautions for blood borne pathogens.

Condition, Disease, Agent	**HEPATITIS B and C (Acute)** 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, or transfusion) or by sexual contact; HB can potentially be transmitted by close family contact (e.g. sharing toothbrushes).
Contagious Period	Anytime virus is present in blood, secretions and body fluids containing blood, in genital secretions (semen, vaginal fluid) and for many weeks before onset of symptoms. Chronic carrier states for both viruses are common.
Incubation	HBV is an average of 90 days with a range of 45-160 days. HCV is usually 36-63 days with a range of 14 days to 6 months.
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 students with suspicion of hepatitis for medical evaluation. School exclusion is unnecessary; however, the student 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 with a infected individual is indication for serologic testing and immunization for Hepatitis B.
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 unvaccinated person at increased risk of hepatitis B infection should receive vaccine.
Public Health Action	Report cases to the Department of Health. Provide vaccine.
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. Use standard precautions for blood borne pathogens.

School Action	▪ 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 for blood borne pathogens. Monitor 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 blood borne pathogen exposure plan should receive Hepatitis B vaccine. ▪ Provide prevention education. ▪ Refer sexual contacts of an infected person to the Department of Health for testing and appropriate immunization. ▪ Respect the right to confidentiality of infected persons.

Condition, Disease, Agent	**HERPES SIMPLEX-GENITAL INFECTION** Herpes simplex virus (HSV), type 2 http://www.health.state.nm.us/epi/CDManualFinal04.pdf
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; indirect contact highly unlikely although virus remains viable on contaminated objects at least for several hours
Contagious Period	7-50 days following onset of primary infection and for up to a week after onset of recurrent episode; during asymptomatic shedding of the virus
Incubation	2-14 days for primary infection
Diagnosis	Diagnosis is made on the clinical evaluation of lesions that are initially thin-walled vesicles and/or blisters that ulcerate on moist surfaces or crust on dry skin; laboratory testing includes cultures
Management of Case	Refer for medical evaluation for apparent primary infection or for frequent or severe recurrences. Genital herpes in a student may be indicative of sexual abuse. Specific treatment: Oral (or in severe cases, intravenous) acyclovir is effective in shortening the duration of the primary and recurrent episodes including viral shedding. Those with frequent recurrences may suppress them with continuous oral acyclovir.
Management of Contacts	Refer contacts for medical evaluation and provide prevention education.
Public Health Action	Not reportable condition

School Action	▪ 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, report to Child Protective Services or other appropriate authority. ▪ Provide prevention education to include safer sex practices.

Condition, Disease, Agent	**HERPES SIMPLEX, NON-GENITAL INFECTIONS** Herpes simplex virus (HSV), type 1 http://www.health.state.nm.us/epi/CDManualFinal04.pdf
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 (rarely other types of dermatitis) are at risk for widespread herpetic infection of their skin lesions.
Transmission, Exposure	Contact with oral secretions of infected person with or without symptoms; contact with open lesions from which eyes or genitals may become infected
Contagious Period	7-50 days following onset of 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	2-12 days for primary infection.
Diagnosis	Diagnosis is made on clinical evaluation of the lesions which are initially thin-walled vesicles and/or blisters that ulcerate on moist surfaces or crust on dry skin; laboratory cultures to confirm diagnosis
Management of Case	Refer for medical evaluation for apparent primary infection or for frequent or severe recurrences. Oral (or in severe cases, intravenous) acyclovir is effective in shortening the duration of primary episode and reduces viral shedding. Those with frequent recurrences may be able to suppress them with continuous oral acyclovir. Topical Carmex and camphor products have been used as OTC treatment.
Management of Contacts	Protect students 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. Promoting the avoidance of kissing and sharing drinking utensils with infected is important.
Public Health Action	Not reportable condition

School Action	▪ School exclusion is not necessary. ▪ Infected students should be taught to frequently disinfect surfaces and objects routinely contaminated with oral secretions. ▪ Persons in physical contact with students who have active lesions and who cannot control their oral secretions should wash their hands frequently and use standard precaution for blood-borne pathogens. ▪ Exclude athletes in contact sports from competition while they have open lesions that cannot be covered. ▪ Disinfect sports equipment (especially mats) after practice and competition. ▪ Provide prevention education.

Condition, Disease, Agent	**HIV INFECTION/AIDS (ACQUIRED IMMUNODEFICIENCY SYNDROME)** Human immunodeficiency virus (HIV)
Clinical Description	Initial infection with HIV may be subclinical or may cause an acute mononucleosis-likeliness 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 not a risk with casual household, school or social contact.
Contagious Period	Early on after infected 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	Students with HIV infection may be absent from school frequently and may need medication frequently and regularly at school. 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. 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. Practice standard precautions.

School Action	▪ School exclusion is not appropriate (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. ▪ Monitor 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 with as normal a school environment as possible.

Condition, Disease, Agent	**IMPETIGO** http://www.health.state.nm.us/epi/CDManualFinal04.pdf Group A *Streptococci* (GAS), *Staphylococcus aureus*
Clinical Description	Flat yellow crusty or weeping lesions seen commonly on face and arms that are usually superficial at first proceeding through vesicular, pustular and encrusted stages. 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 transmission most common; respiratory droplets of asymptomatic
Contagious Period	Variable, at least while lesions are actively weeping and crusting and carrier state exists; not contagious 24 hours after initiation of effective antibiotic.
Incubation	Streptococcal – 7to 10 days; staphylococcal – 4 to 10 days
Diagnosis	Clinical diagnosis is reliable but culture and sensitivity of the base of the lesion is recommended.
Management of Case	Local skin infection is managed by cleaning the area and applying appropriate topical antimicrobial ointment under primary care provider's direction. Systemic antimicrobial therapy is usually not indicated unless an infection spreads significantly or there is impetigo in multiple family members or school attendees. A student 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. Use standard precautions for blood borne pathogens.
Public Health Action	Outbreaks of impetigo and complications of streptococcal infection should be reported to the Department of Health.

School Action	▪ 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. ▪ Use standard precautions for blood borne pathogens.

Condition, Disease, Agent	**INFLUENZA** http://www.health.state.nm.us/epi/CDManualFinal04.pdf Influenza virus (types A and B)
Clinical Description	Acute respiratory infection ("flu") characterized by sudden onset of fever, chills, headache, malaise, myalgias 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	1 day prior to onset of symptoms and up to 5 days after onset
Incubation	1-4 days
Diagnosis	Clinical diagnosis is usually reliable when symptoms are typical and influenza is circulating in the community. Viral antigen testing of nasal or throat swab can be used for point of care diagnosis. Cultures for influenza take more time for results but can identify the influenza type which is important for surveillance activities and in developing influenza vaccine.
Management of Case	Children and adults with clinical influenza should be sent home until fever (greater that 100°F) subsides. Fluids are important to maintain hydration. Bed rest, analgesics (other than aspirin) may help symptomatically. The influenza cough may persist for weeks and may require some limitation of activity, especially for those with asthma. Students should not return to school until they are afebrile (less than 100°F) and systemic symptoms have subsided (usually 3-7 days).
Management of Contacts	All individuals at risk for influenza complications or in contact with persons at increased risk should receive influenza vaccine annually as soon as it is available. Encourage good hand hygiene and appropriate disposal of contaminated articles.
Immunization	Influenza vaccine changes each year, so it should be repeated annually.
Public Health Action	Notify the Department of Health (505-827-0006) when outbreaks of respiratory disease appear in a school.

School Action	▪ Exclude students and staff with clinical influenza until afebrile (less than 100°F) and symptoms 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 students and staff through school health program. ▪ Consider student absenteeism and staff availability when making decisions regarding school closure when outbreaks occur. ▪ Provide prevention education.

Condition, Disease, Agent	**MENINGOCOCCAL DISEASE** http://www.health.state.nm.us/epi/CDManualFinal04.pdf *Neisseria meningitidis* (meningococcus), *Haemophilus influenzae* type b ("Hib"), *Streptococcus pneumoniae (pneumococcus*)
Clinical Description	Invasive bacterial disease is manifested by fever, chills, malaise, rash that may be macular maculopapular or petechial, 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; may be 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 3-4 days with a range of 2-10 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 meningitis is a life-threatening illness requiring immediate hospitalization and antibiotic treatment and respiratory isolation for 24 hours after initiating therapy. The infected student may return to school at the advice of a medical provider with any limitations specified by him/her.
Management of Contacts	It is important to start surveillance of contacts of infected person for antibiotic prophylaxis. Secondary cases of meningococcal disease 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; this may include close friends at school. All young contacts in child care should be considered for prophylaxis. Secondary cases of Haemophilus influenza 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 influenze (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 and Response Division will coordinate contact assessment and implementation for antibiotic prophylaxis and surveillance.

School Action

- 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/vaccination of contacts as well as communication with parents and staff.
- Provide prevention education.
- Exclude infected students until a release to return is provided by the primary care provider and accommodate students with any specified limitations.

Conditions, Disease, Agent	**MENINGITIS (VIRAL or ASEPTIC)** http://www.health.state.nm.us/epi/CDManualFinal04.pdf Enteroviruses (ECHO and Coxsackie), other viruses
Clinical Description	Symptoms include fever, headache, stiff neck, back pain, vomiting, malaise, drowsiness, altered consciousness, prostration and possibly 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 infected secretions from throat or nose; fecal-oral contamination for many enteroviruses
Contagious Period	Weeks to months depending on causative agent; most infectious during stage of illness
Incubation	Variable depending on virus, 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 infected student has recovered, he/she may return to school with 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 setting, 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 immediately. Good hand washing practices by all should be enforced at school.
Immunization	None available
Public Health Action	Not required

School Action	▪ Refer suspected students for medical evaluation. ▪ School exclusion is not necessary unless prescribed by medical provider. ▪ Provide prevention education to include good hand washing practices.

Condition, Disease, Agent	**MRSA (METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS)** *Staphylococcus aureus* bacteria http://www.health.state.nm.us/epi/CDManualFinal04.pdf
Clinical Description	MRSA is a type of Staphylococcus aureus that is resistant to some antibiotics including methicillin. "Staph" aureus is found on the skin of many people, but does not cause infection or illness until these bacteria get into a cut, scrape or other break in the skin. Many people carry staph bacteria on their skin but have no symptoms of disease. Infections can look like a pimple, rash, boil or open wound.
Transmission, Exposure	Direct skin-to-skin contact such as holding hands or engaging in contact sports with hands being most common instrument of transmission; indirect through contact with items touched or used by infected person or staph carrier such as razors, towels, athletic equipment, clothing
Contagious Period	As long as bacteria is carried on the skin
Incubation	Variable and indefinite
Diagnosis	Laboratory testing
Management of Case	Early treatment can help prevent MRSA infection from worsening. All skin lesions should be covered with clean, dry pads. The infected student may need to avoid certain activities such as contact sports or gym activities so that lesion dressing remains intact and the body can heal. Gloving, hand washing and proper disposal of contaminated materials is essential in care delivery. Prescribed antibiotics should be take as directed; provider should be contacted if improvement is not evident in a few days. Students or staff infected or with suspect infection need **not** be excluded from school. Public Health (505-827-0006) should be contacted if more than one diagnosed case of MRSA is suspected in the same school.
Management of Contacts	Good hand washing practices and observation are important for known contacts. There is no vaccine or preventative medication available for MRSA exposure.
Immunization	None available
Public Health Action	Support services are available through Public Health as well as follow-up services if more than one MRSA case is suspected in the same school.
Prevention Education	Wash hands frequently with soap and water; keep cuts and scrapes clean with soap and water and covered with dry pads; do not pick, touch or scratch skin lesions or touch another's sores/lesions; avoid skin contact and sharing personal items with anyone suspected of having MRSA; to prevent antibiotic-resistance from occurring do not request antibiotics for colds or other viruses and take all antibiotics prescribed even if symptoms disappear before finishing the medication.

School Action	▪ Do not exclude students or staff with MRSA infections or suspected infections. ▪ Alert parents of school cases only after collaboration with Public Health. ▪ Monitor cases and suspected cases. ▪ Encourage frequent hand washing and proper coverage of all skin wounds. Encourage daily showers or baths. ▪ Ensure access to sinks, soap and clean towels and/or alcohol-based sanitizers. ▪ Infected students may need to avoid gym activities and contact sports to prevent wound dressings from coming off. ▪ Clean athletic equipment daily if used by more than one individual. ▪ Follow standard precautions when providing care for infected student. ▪ Report **more than one case** to Public Health (505-827-0006).

Condition, Disease, Agent	**MONONUCLEOSIS (INFECTIOUS MONONUCLEOSIS, MONO)** Epstein-Barr virus (EBV)
Clinical Description	Persons with "mono" usually have fever, sore throat which may be severe, splenomegaly and enlargement of cervical lymph nodes. Malaise and fatigue may be severe and prolonged. 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 saliva and by droplets contaminating hands or objects. Kissing facilitates disease spread. 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 for as long as a year or more and is probably the source of most new infections.
Incubation	4-6 weeks
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 are usually positive by the second week of illness.
Management of Case	Because of a small risk of rupture of the enlarged spleen, infected students should be excluded from contact sports until the spleen has returned to normal size. There is no specific treatment for "mono". Infected students 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. Discourage engaging in activities involving exchange of saliva with infected individuals.
Immunization	None available
Public Health Action	EBV infections are not reportable.

School Action	▪ Refer children with suspected infectious mononucleosis for medical evaluation. ▪ School exclusion is not appropriate unless student is unable to participate in routine activities. ▪ Exclude student with enlarged spleen from contact sports until medical clearance is received. ▪ Provide prevention education.

Condition, Disease, Agent	**MUMPS** http://www.health.state.nm.us/epi/CDManualFinal04.pdf Mumps virus, RNA virus
Clinical Description	Mumps is an acute viral infection characterized by fever and enlargement of the salivary glands. Pancreatitis, orchitis in males, oophoritis in females, and encephalitis may occur, but rarely. Complications are more common in adults.
Transmission, Exposure	Direct airborne transmission or respiratory droplets or direct contact with saliva of infected person
Contagious Period	6-7 days before until 9 days after swelling begins
Incubation	16-18 days after exposure with a range of 12-26 days
Diagnosis	Clinical diagnosis of symptomatic mumps is reliable in outbreaks; however, iIsolated cases of salivary gland swelling may be caused by other viruses, blockage of a salivary duct or bacterial infection. Virus isolation and serology including detection of IgM antibody are recommended. Confirmation of the disease is important before extensive surveillance or immunization is undertaken.
Management of Case	Refer students with suspect mumps for medical evaluation. There is no specific treatment; most school-age children are only mildly ill. School exclusion should be for 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. Contacts with no prior history of mumps illness or immunization should be excluded from school from the 12th through 25th day after exposure and should be considered for mumps vaccine. Testing adults 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 students are required to have two doses of MMR vaccine before school entry.
Public Health Action	Report cases and suspect cases to the Department of Health.

School Action	▪ Refer students with enlarged salivary glands for medical evaluation. ▪ Exclude students with confirmed mumps for 9 days following onset of swelling. ▪ Exclude susceptible contacts from 12th through 25th day after exposure. Excluded students can be readmitted immediately after immunization. ▪ Exclude students who are exempted from mumps immunization until at least 26 days after onset of swelling in the last contact case of exposure. ▪ Provide prevention education.

Condition, Disease, Agent	**PEDICULOSIS (HEAD LICE)** Pediculus humanus capitis, 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	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 if used properly. Education in the proper use of products should follow specific manufacturers' recommendations. 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. 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.
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	▪ 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	**PERTUSSIS (WHOOPING COUGH)** http://www.health.state.nm.us/epi/CDManualFinal04.pdf *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 1-2 weeks; the paroxysmal stage with increasingly severe spasms of cough with post-tussive whoop or vomiting lasting 2-6 weeks; and the convalescent stage with gradual lessening of coughing spasms disappearing in 2-6 weeks. Infants under six months of age may have apnea but no whoop. Complications may include pneumonia, seizures, encephalopathy and death. Less serious complications are otitis media, anorexia and dehydration.
Transmission, Exposure	Direct person-to-person by respiratory droplets or by direct contact with respiratory secretions from infected person
Contagious Period	From onset of symptoms until 3 weeks of coughing; most contagious period is the first two weeks of cough
Incubation	7-10 days with range of 4-21 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 suspect or confirmed cases until after 5 days of antibiotic treatment .
Management of Contacts	Identify close contacts and refer them for preventive treatment. Close contacts include those with direct face-to-face exposure with 3 feet of coughing case, direct contact with respiratory, oral or nasal secretions, those sharing confined space for a minimum of 1 hour with coughing case. All students under 7 years of age who have not completed the primary series or did not receive a booster dose after 4 years of age should receive a pertussis vaccine booster. All students 10 years of age and older who have not had a pertussis booster during past 5 years should receive a dose of Tdap; those with less than 5 years should be considered for Tdap depending on benefits and risks.
Immunization	For school entry students are required to have completed at least 4 doses of pertussis-containing vaccine with one dose received on/after 4th birthday. Tdap is required for 7th and 8th grade entry and recommended for all higher grades and adults younger than 64 years if more than 5 years since last pertussis-containing immunization.
Public Health Action	Report suspected and confirmed cases to the Department of Health. The Epidemiology and Response Division will coordinate testing, contact identification and treatment.

School Action

- Exclude cases and symptomatic contacts until completion of 5 days of antibiotic treatment or until three weeks after onset of cough if not treated.
- Refer suspected cases for medical evaluation and treatment immediately and monitor school for additional cases for 21 days after last contact with known case(s).
- Report confirmed and suspect cases to Department of Health (505-827-0006) who will coordinate all follow up and parental notification.
- Review immunization status of students and staff to identify susceptible contacts.
- Provide access to immunization.
- Provide prevention education.

Condition, Disease, Agent	**PLAGUE** http://www.health.state.nm.us/epi/CDManualFinal04.pdf *Yersinia pestis* (bacteria)
Clinical Description	Plague is a flea-transmitted bacterial infection to humans through rodents. The most common form is bubonic plague; less common forms are septicemic and pneumonic. Bubonic plague: The primary site of inoculation may resemble an infected insect bite or the site may be unapparent. 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. 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. Pneumonic plague: This condition may develop following bacteremia with cough and production of bloody sputum and can be spread person-to-person via airborne transmission. Plague is treatable but has high fatality rate with inadequate or delayed treatment.
Transmission, Exposure	Humans 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, (4) ingestion of raw or undercooked meat of infected animal.
Contagious Period	Pneumonic plague - from onset of cough until completion of several days of antibiotic therapy. Bubonic and septicemic plague - usually not contagious
Incubation	2-8 days for bubonic plague; 1-6 days for human-to-human transmission of pneumonic plague.
Diagnosis	Plague may resemble wound infections with secondary lymphadenitis; any patient presenting with these symptoms and living in known plague area should be evaluated for plague. Cultures should be obtained from blood and apparent sites of infection (such as the affected lymph node).
Management of Case	Pneumonic cases and contacts should be treated with antibiotic therapy and kept under surveillance. They should be excluded from school until completion of 48 hours of antibiotics and there is favorable clinical response. School exclusion of bubonic and septicemic plague cases is not appropriate.
Management of Contacts	Any suspect plague case should be referred immediately for medical evaluation. Contacts of pneumonic plague case 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 and should be considered for prophylaxis or surveillance.
Prevention Education	Reduce rodent activity near homes and schools; control fleas on domestic animals; avoid contact with dead or ill animals; rodent proof houses and outbuildings; wear rubber gloves when handling wild game; stack wood piles 12 inches above ground and 100 feet away from house.
Public Health Action	Report cases or suspect cases to Department of Health (505-827-0006).
School Action	▪ Refer possible cases immediately for medical evaluation. ▪ Exclude from school pneumonic cases until completion of 48 hours of antibiotic; do not exclude septicemic or bubonic cases unless ill. ▪ Assist in identifying close contacts; contacts need not be excluded from school unless they are symptomatic of pneumonic plague. ▪ Report to the Department of Health rodent activity (especially prairie dogs and ground or rock squirrels) on or near school grounds as well as unusual numbers of dead rodents in the area.

Condition, Disease, Agent	**RUBELLA (GERMAN MEASLES, THREE-DAY MEASLES)** Rubivirus http://www.health.state.nm.us/epi/CDManualFinal04.pdf
Clinical Description	A diffuse maculopapular rash is often the first sign of rubella disease; however, a mild prodromal illness, with low-grade fever, malaise, coryza, conjunctivitis and headache may occur 1-4 days before the rash appears. It appears first on the face but spreads rapidly over the entire body. The rash consists of small, flat (nonpalpable), reddish-pink spots that rarely last more than 3 days. Adolescents and adults with rubella may have arthritis affecting a few joints and 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 nasal pharyngeal secretions or urine from congenital rubella cases; crossing placenta and infecting fetus in infected pregnant women
Contagious period	A few days before the rash develops to 5 to 7 days after the rash begins; 1 year or longer after birth in congenital rubella cases for urine transmission
Incubation	Usually 16 to 18 days with range of 14- 23
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.
Management of Case	There is no specific treatment. School exclusion is appropriate for 7 days after onset of rash.
Management of Contacts	Contacts known to be susceptible should be immunized immediately. Adult contacts born before 1957 are presumed to be immune; others 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 medical provider immediately. Exclusion from school not appropriate.
Immunization	Two doses of rubella (MMR) vaccine are required for school entry. Pregnant females should not be vaccinated but may be considered for IG prophylaxis. All age-appropriate females should be counseled to avoid pregnancy for 3 months after immunization.
Public Health Action	Report all suspected or confirmed cases NM Department of Health (505-827-0006). Identification and immunization of susceptible contacts will be coordinated by the Epidemiology and Response Division.

School Action	▪ Refer all suspected cases for medical evaluation. ▪ Exclude infected students from school until 7 days after onset of rash. ▪ Do not exclude contacts unless symptomatic. ▪ Enforce 2-dose MMR immunization requirement for school entry. ▪ Report suspected and confirmed cases to the Department of Health. ▪ Provide prevention education to include risk of immunization regarding pregnancy and concerns for pregnant contacts.

Condition, Disease, Agent	**RUBEOLA (MEASLES)** http://www.health.state.nm.us/epi/CDManualFinal04.pdf 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 complications.
Transmission, Exposure	Droplet and airborne transmission of respiratory secretions that may circulate in the air up to 4 hours after infected person leaves a room.
Contagious Period	1-2 days before onset of initial symptoms; 3-5 days before onset of rash until 4 days after appearance of rash
Incubation	Average of 10 days from exposure to onset of rash with a range of 7-18 days or 8-12 days from exposure to onset of symptoms; 14 days from exposure until rash appears
Diagnosis	Clinical evaluation with history of symptoms is useful with confirmation by lab culture of respiratory secretions.
Management of Case	Refer suspect cases immediately for medical evaluation. There is no specific treatment. School exclusion is appropriate until 4 days after rash onset.
Management of Contacts	Immunization records should be reviewed to determine susceptible contacts and access to immunization should be provided within 72 hours of exposure. Immune globulin may be given to susceptible contacts who should not receive vaccine, including pregnant females and those who refuse vaccination. Susceptible contacts should be excluded from school until 21 days after rash onset in the last case contact 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 21 days after rash onset in the last case contact.
Immunization	Two doses of measles vaccine (MMR) is required for school entry.
Public Health Action	All suspect and confirmed cases should be reported to the Department of Health immediately (505-827-0006).

School Action

- Refer suspect cases immediately for medical evaluation.
- Report confirmed and suspected cases to NM Department of Health.
- Exclude cases from school until 4 days after onset of rash.
- Review immunization records to identify susceptible individuals.
- Exclude susceptible individuals until 21 days after onset of rash in the last case.
- Provide prevention education to include risks regarding pregnancy.

Condition, Disease, Agent	SCABIES http://www.health.state.nm.us/epi/CDManualFinal04.pdf *Sarcoptes scabiei*
Clinical Description	Lesions caused by infestation of scabies mites are characterized by an intensely pruritic, red, vesiculopapular eruption caused by adult female mites burrowing under the skin to lay eggs. The scabies burrow appears as a gray or white threadlike line. Lesions are commonly found on finger webs, wrists and elbows, axillary folds, belt line; in men on thighs and external genitalia; and women on nipples, abdomen and lower portion of buttocks.
Transmission, Exposure	Direct, prolonged contact, including sexual contact, with infected skin
Contagious Period	Until mites and eggs are destroyed by treatment
Incubation	2-6 weeks from exposure to start of symptoms for the initial infestation; 1-4 days after re-exposure
Diagnosis	Exam shows typical excoriated papules and burrows. Microscopic exam of skin scrapings shows the mite, eggs, and fecal deposits.
Management of Case	Infested students should be excluded from school until initial treatment is completed. Treatment: with nonprescription formula containing permethrin is recommended; lindane solution is an alternative if retreatment is necessary but it is more toxic. Although they are not usually responsible for transmission of the mite, clothing and bedding should be laundered in hot water. Items that cannot be washed should be isolated in plastic bags for 10-14 days.
Management of Contacts	Close contacts should be examined for signs of infestation. Household contacts are usually infested and need treatment; therefore, all members of household should be treated concurrently to prevent reinfestation. Manifestation of infestations can appear as late as 2 months after exposure, during which time infected person can transmit scabies.
Public Health Action	Not a reportable condition; assistance with treatment available at Public Health Offices

School Action	▪ Exclude infested students at the end of the school day until they have received initial treatment. ▪ Examine close contacts for infestation. ▪ Provide prevention education including material regarding treatment recommendations.

Condition, Disease, Agent	**STREPTOCOCCAL INFECTIONS (STREPTHROAT))/SCARLET FEVER** *Streptococcus pyogenes* Group A http://www.health.state.nm.us/epi/CDManualFinal04.pdf
Clinical Description	Classic strepthroat is characterized by severe sore throat, malaise, toxicity, fever, tender lymph nodes in the neck, and a purulent exudate on the tonsils. Untreated strepthroat develops complications including otitis media, sinusitis, and abcesses on the tonsils and pharynx. Scarlet fever is a strepthroat plus a characteristic fine, sand-papery erythema rash prominent on the cheeks, trunk and extremities but less evident around the mouth, inside elbows and behind knees. Invasive streptococcal infections may follow wound infections including infected varicella lesions or respiratory infections.
Transmission, Exposure	Transmitted person-to-person mainly via respiratory secretions; outbreaks from food or milk contamination; recurrent disease from ongoing contact with carriers
Contagious Period	Weeks to months; 10-21 days after acute illness or until 14 hours after treatment
Incubation	2 to 5 days for pharyngitis
Diagnosis	Rapid strep test from throat swab or throat culture supports clinical evaluation.
Management of Case	Suspect cases should be referred for medical evaluation. Referral is urgent if high fever, marked toxicity or respiratory distress 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 (505-827-0006).

School Action	▪ Refer suspect 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. ▪ Provide prevention education.

Condition, Disease, Agent	**TINEA CAPITIS, CORPORIS, CRURIS and PEDIS** (Ringworm fungal infection of scalp, body, groin and feet) *Microsporum* and *Trichophyton.* http://www.health.state.nm.us/epi/CDManualFinal04.pdf
Clinical Description	Frequently itchy patches and ring-shaped lesions on the scalp or skin of the trunk or extremities caused by a fungus. Lesions are usually reddish, scaly, crusted at the margins with central clearing. Fissuring may occur in skin folds. Balding patches may occur on scalp; hairs are broken off near the skin or scalp rather than being completely absent. If bacterial infection develops because of scratching, lesions may become inflamed with a bloody, purulent discharge.
Transmission, Exposure	Direct or indirect contact with skin or scalp lesions of infected persons or animals; contact with contaminated articles such as 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, estimated to be 10-14 days
Diagnosis	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 suspect cases for medical evaluation and treatment. Scalp lesions require oral therapy for at least 4 weeks. Other varieties require topical or oral antifungal therapy. Students should avoid public areas conducive to transmission such as gyms and swimming pools. 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. Monitor contacts as long as potential for exposure continues.
Public Health Action	Not a reportable condition

School Action	▪ Refer suspect cases for medical evaluation and treatment. ▪ School exclusion is not necessary. ▪ Observe contacts for development of lesions. ▪ Require disinfection of appropriate sports equipment standing water where fungus may grow. ▪ Encourage covering of lesions. ▪ Discourage sharing of personal items with infected case. ▪ Provide prevention education.

Condition, Disease, Agent	**TUBERCULOSIS (TB)** *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.
Transmission, Exposure	Respiratory route by droplet nuclei usually over a period of time with close contact with active disease case; transmission risk dependent on number of bacteria present in secretions, efficiency of coughing, closeness of contact, airspace size containing infected droplet nuclei
Incubation	2-12 weeks from exposure to development of positive tuberculin test; clinical disease most likely within 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 basis of physical examination may be suggestive of tuberculosis, especially if individual 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; it does not necessarily indicate that the infection is active. Laboratory diagnosis made by microscopic examination and culture of sputum or other specimens confirms the diagnosis and identifies appropriate antimicrobial treatment.
Management of Case	Students and staff with persistent cough (longer than three weeks) should be referred for medical evaluation. For active disease, completion of treatment is critical to prevent relapse and development of secondary drug resistance. Active disease cases should be excluded from school until released by the state Tuberculosis (TB) Control Program, usually after 2 weeks of completed therapy and coughing has subsided.
Management of Contacts	The TB Control Program will coordinate tuberculin testing, and determine the need for chest x-ray, physician evaluation, and preventive treatment of contacts.
Vaccine	BCG vaccine is administered 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	▪ Refer students and staff with chronic cough lasting longer than three weeks for medical evaluation. ▪ Report suspected or confirmed cases to the Department of Health. ▪ Exclude students and staff with active tuberculosis from school until determined by the TB Control Program to be non-contagious. ▪ Provide preventive education.

Condition, Disease, Agent	**VAGINITIS** *Trichomonas vaginalis, Candida*
Clinical Description	Thick white (Candida) or malodorous gray (Trichomona) vaginal discharge, often with external irritation that usually includes itching or dysuria.
Transmission, Exposure	Person-to-person genital contact or genital contact with contaminated articles
Incubation	Indeterminate
Contagious Period	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 causative agent. Sexual contact should be avoided during period of infection and during treatment of patient and partner(s).
Management of Contacts	Sexual partners are usually asymptomatic, but they should be evaluated and treated in the case treatment is to be effective long term.
Public Health Action	Promotion of "safer sex" behavior, including condom use, for all nonmutually monogamous sexual contacts is indicated.

School Action	▪ Provide preventive education with sex education curriculum. ▪ Refer suspect cases for evaluation and appropriate treatment. ▪ School exclusion not appropriate. ▪ Provide preventive education to include safer sex education.

SCHOOL HEALTH AND SEXUALLY TRANSMITTED DISEASES (STD'S)

INTRODUCTION

STDs are very common infections in the United States and in New Mexico. Viral STD's including HPV (Human Papilloma Virus) which causes genital warts and is linked to cervical cancer) and genital herpes are on the increase. New Mexico currently has one of the highest rates of chlamydia in the nation. Rates of gonorrhea and chlamydia are highest in 15 to 19 year old girls and young adult males who are 20 to 24 years of age, the cause being many teenage girls have young adult males for sexual partners. Studies have shown that teenagers (>50%) are having intercourse by the time they finish high school. Teenagers often practice "serial monogamy" and are therefore more likely to have several sex partners in a given year. Many teenagers do not use any contraception and many are not using barrier methods such as condoms to protect themselves from infections. All these factors help to explain the high STD rates among our teenage population. School nurses in middle schools and high schools are likely to see students with these problems.

SCHOOL NURSE ROLE

School Nurses can help address these problems by conveying a simple and nonjudgmental message to those students with whom they interact:

- Delay having sexual intercourse until you are ready. Despite the sexualized cultural climate in which we live, it is important to remind teenagers that not everyone is having sexual intercourse
- If you are going to have sex, use condoms to prevent STD's and reliable contraception such as birth control pills or a long[acting progesterone injection
- Limit number of sexual partners
- Use condoms to protect yourself from STD's

Students should be encouraged to talk to their parents about sexual issues that concern them. The ideal situation is for teens to talk to a parent or other adult family member about their sexual feelings, intimate relationships, about becoming sexually active, birth control, and STDs. However, the reality is that many students are unwilling or unable to broach these subjects with their families. Sometimes the student simply needs encouragement to open lines of communication with a parent or relative about these subjects. Sometimes, however, it is the parent who makes it clear that they are unwilling to address these matters with their child. Some students fear parental violence or being banned from the home should their parent or family become aware of their sexual activities. In these situations the school nurse can be of assistance in referring the student to proper medical or counseling interventions.

The School Nurse can also help students by letting them know that they are legally entitled to receive confidential medical services for family planning and STDs. Many students believe that their parents will be told that they have an STD. This is not true. Students can be referred to a School Health Center or to a Department of Public Health clinic where they may receive free and confidential services for the diagnosis and treatment of a STD, for prevention services such as the provisions of condoms, or for family planning services. It is most helpful for School

nurses to know the public health nurses in their communities in order to facilitate such referrals especially in a crisis or emergency situation.
When questioning a student about sexual activity, it is important that a nurse not assume that the student is heterosexual. It would be best to ask directly whether the student has sexual partners who are males, females or both. This will enable a gay, bisexual or lesbian student to disclose their activities in a more supportive and nonjudgmental context.

Students who present to the school nurse with possible symptoms of a STD should be asked about their risks for STDs and referred to a medical facility which can diagnose and teat theses problems. Many STDs have no symptoms or may have only vague and non-specific symptoms, especially in girls.

STD SYMPTOMS

Male:

- A penile discharge
- Burning with urination
- Any sore, growth or ulcer on the penis or groin area

Female:

- An abnormal vaginal discharge, especially with itching, burning or odor
- A sore, growth or ulcer on the external or internal genitalia
- Pain with intercourse
- Burning on urination
- Abnormal vaginal bleeding
- Lower abdominal pains with or without vomiting, nausea or fever

STD TESTS

New tests are available which enable gonorrhea or chlamydia to be diagnosed on a urine specimen. Contact your local Department of Health Office to determine availability of these tests. These PCR [polymerase chain reaction] and LCR [lygand chain reaction] tests are extremely accurate and are well accepted by teens since they do not require a potentially embarrassing genital or speculum examination. They can be used to screen students who are sexually active and who have no symptoms; however, any student who has symptoms of a STD should be FULLY examined. These urine tests can be used during sports physicals, in school-wide screening campaigns, for girls who are having pregnancy tests or upon request in partnership with the Department of Health (DOH). All positive tests should be treated according to DOH protocols.

PUBLIC HEALTH SERVICES

Every county in the state of New Mexico has at least one public health office where people with STDs including HIV may be evaluated or referred for services. Disease Prevention Specialists provide outreach and follow up services through public health offices across the state. A school nurse can be a valuable resource for information about sexuality, contraception, and STD's. Excellent written materials, videos, and posters are available from many sources. Contact your local Public Health Office for obtaining or borrowing these materials.

TUBERCULOSIS (TB) SCREENING GUIDELINES

INTRODUCTION

As Of July 30, 2004 , transmission-free certification for tuberculosis (TB) is no longer a state-mandated requirement for employment in health facilities, schools and day-care centers. Therefore, TB skin testing of new employees is, in general, no longer required for new employees in schools and pre-schools.

As a result of a public hearing on June 28, 2004 and prior research, New Mexico Administrative Code 7.4.4 (Control of Communicable Disease in Health Facility Personnel) has been repealed. This code required persons employed or who were seeking employment or who volunteered in health facilities, schools and day care centers to be tested and maintain certification that they were free from TB in a transmissible form.

New Mexico has been a low incidence state for TB since 2000, which means that there are fewer than 3.5 TB cases per 100,000 persons. In the early 1990s the American Thoracic Society, in conjunction with the Centers for Disease Control and Prevention, encouraged tuberculin skin testing only of individuals at high-risk for TB and discouraged all mandated and mass pre-employment screenings. State TB programs were encouraged to take the lead in determining which groups should be screened based on local TB data. Screening low-risk individuals often results in false positive tests and subsequent unnecessary treatment, diverting financial and human resources from other priority activities.

GUIDELINES

- Tuberculin skin testing for employment in schools and daycare centers of low-risk individuals is not required in New Mexico.
- The NM Department of Health will offer screening the following high-risk individuals.
    - Close contacts to active TB cases.
    - HIV infected persons.
    - Non-US born persons, including children, who have emigrated within the past 5 years from areas of the world where TB incidence is high.
    - Medical risks with immunosuppressive diseases to be determined individually by private or public medical providers.
    - Persons who inject illicit drugs.
    - Healthcare workers who work in hospitals with isolation rooms.
    - Employees and residents of residential drug treatment centers, nursing homes and correctional facilities.

NEW MEXICO REGISTER REFERENCE

New Mexico Register, Volume XV, Number 14, July 30, 2004
http://www.nmcpr.state.nm.us/nmregister/xv/xv14/7.4.4repeal.htm

This part 7 NMAC 4.4, Control of Communicable Disease in Health Facility Personnel (filed October 18, 1996) is hereby repealed effective July 30, 2004.

Condition, Disease, Agent	**VAGINITIS** 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	▪ 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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