

Communicable Disease Reference Chart for School Personnel

DISEASE	INCUBATION PERIOD	TRANSMISSION	COMMON SYMPTOMS	RECOMMENDATIONS
Chickenpox* (Varicella)	10-21 days, usually 14-16 days. (Incubation period in persons who receive VariZIG or IVIG extends through day 28.)	By direct contact with vesicular fluid or by airborne spread from respiratory tract secretions. Infectious from 1 to 2 days before rash onset until all lesions have dried/crusted over and no new lesions appear within a 24 –hour period (average is 4-7 days).	Sudden onset with slight fever, other systemic symptoms and itchy eruptions which become vesicular (small blisters) within a few hours. Lesions commonly occur in successive crops, with several stages of maturity present at the same time. Typically, vesicular rash consisting of 250-500 lesions in varying stages of development (papules, vesicles) and resolution (crusting). Communicable for as long as 5 days (usually 1-2 days) before eruption of vesicles and until all lesions are crusted (usually 5 days). Communicability may be prolonged in immunocompromised people.	CASE: Exclude from school or child care until the rash of case with uncomplicated varicella has crusted or, in immunized cases without crusts, until no new lesions appear within a 24-hour period. Additionally, exclude from school for at least 5 days after eruptions first appear or until vesicles become dry in immunocompromised patients. Avoid exposure to women in early pregnancy who have not had chickenpox and/or varicella vaccine. CONTACTS: Check vaccination status of contacts and recommend vaccination if needed within 3 to 5 days after exposure. For exposed contacts without immunity, airborne and contact precautions from 8 until 21 days after exposure and until 28 days after for those who received VariZIG or IVIG. On appearance of symptoms, exclude from school.
Conjunctivitis, Acute Bacterial (Pink Eye)	Usually 1-3 days, but variable depending on the causative agent.	By contact with discharges from the conjunctivae or contaminated articles.	Pink or red eyeball with swelling of the eyelids and eye discharge. Eyelids may be matted shut after sleep. May involve one or both eyes.	CASE: Exclude from school while symptomatic or until 24 hours of antibiotic treatment has been completed. CONTACTS: School exclusion not indicated. Important to wash hands thoroughly after contact with eye drainage. Also, do not share any articles that have come into contact with the eyes.
COVID-19 (Coronavirus 2019 infection caused by SARS-CoV-2 virus)	Usually 2-14 days	Primarily by larger droplets (saliva, respiratory secretions) that land on another person’s nose, mouth or eyes. Some evidence that SARS-CoV-2 virus may spread by airborne transmission, but not felt to a primary mode of spread. Also, some evidence that having virus on hands (after touching a contaminated surface) and touching one’s nose, mouth, eyes may transmit virus. However, this is not considered a major mode of spread.	About 45% of patients have no symptoms at all. Patients who develop symptoms may have a wide variety of symptoms of variable severity. Symptoms may include: <ul style="list-style-type: none"> • Fever and/or chills • Cough • Shortness of breath • Headache • Runny nose • Fatigue • Sore throat • Muscle aches/body aches • New loss of taste or smell • Nasal congestion • Nausea and vomiting • Diarrhea 	CASE: Isolate student immediately and exclude from school until student has met criteria to discontinue isolation. Depending on severity of illness, refer student to their own medical provider, urgent care center, or emergency department for further evaluation and treatment. In general, illness is less severe in children than adults. The student will need to be out of school for a defined period. See VDH info for current guidance. CONTACTS: A close contact is defined as someone who was within 6 feet of an infected person (laboratory-confirmed or a clinically compatible illness) for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5-minute exposures for a total of 15 minutes). A close contact also includes someone who had direct exposure to respiratory secretions (e.g., being coughed or sneezed on, sharing a drinking glass or utensils, or kissing). Certain close contacts, based on vaccination and booster status, need to quarantine. See VDH info for current guidance.

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<p>Diarrheal Diseases* (Campylobacteriosis, <i>E. coli</i> O157:H7, Giardiasis, Salmonellosis, Shigellosis, etc.)</p>	<p>Campylobacteriosis: Usually 2-5 days but can be longer (1-10 days).</p> <p><i>E. coli</i> O157:H7: Varies from 1 to 10 days, usually 3 to 4 days.</p> <p>Giardiasis: Usually 1 to 3 weeks.</p> <p>Salmonellosis: Usually, 6-72 hours, but periods of a week or more have been reported.</p> <p>Shigellosis: Varies from 1 to 7 days, typically 1-3 days.</p>	<p>Primarily by the fecal-oral route through direct contact or by ingestion of contaminated (or improperly cooked) food or water. Occasionally, person-to-person among very young children.</p>	<p>Ranges from sudden onset of fever, abdominal pain, diarrhea, nausea, and sometimes vomiting in salmonellosis, to cramps and bloody stools in severe cases of shigellosis and <i>E. coli</i> O157:H7. Dangerous dehydration may occur in younger children. In giardiasis, persons may be asymptomatic or have decreased appetite and weight loss.</p> <p>Diarrhea, abdominal pain, malaise, and fever. Stools can contain visible or occult blood. Immunocompromised hosts can have prolonged, relapsing, or extraintestinal infections.</p>	<p>CASE: Exclude from child care centers until stools are contained in the diaper or when continent cases no longer have fecal accidents and when stool frequency becomes no more than 2 stools above normal frequency for the case, even if the stools remain loose. Stress importance of proper handwashing. In an outbreak setting, consult local health department for clearance to return to school / childcare setting. Please note that other resources advise no return to school until diarrhea has ceased for at least 24 hours.</p> <p>CONTACTS: School exclusion and stool cultures not indicated in absence of symptoms. Contacts who are symptomatic should be excluded until stools are contained in the diaper or child is continent and stool frequency is no more than 2 stools above that child's normal frequency for the time the child is in the program. Stool cultures are recommended for symptomatic contacts, and these children should be excluded from school while evaluation pending. Consult with your local health department for advice during suspected school outbreaks.</p> <p>Thorough hand hygiene and environmental cleaning is very important.</p>
<p>Fifth Disease (Parvovirus B19, Erythema Infectiosum)</p>	<p>Between 4-14 days but can be as long as 21 days.</p>	<p>By contact with respiratory tract secretions and percutaneous exposure to blood or blood products.</p>	<p>Distinctive rash characterized by a vivid reddening of the skin, especially of the face, which fades and recurs; classically, described as a "slapped cheek appearance." The rash can fluctuate in intensity and can recur with environmental changes, such as temperature and exposure to sunlight, for weeks to months. Mild symptoms of fever, body aches, and headache may occur 7-10 days before rash.</p>	<p>CASE: Exclusion from school not indicated beyond school-based policies about fever.</p> <p>CONTACTS: School exclusion not indicated. Pregnant women and immunocompromised persons should seek medical advice.</p>
<p>Hepatitis A*</p>	<p>From 15-50 days, average 28 days.</p> <p>All suspected or confirmed cases of hepatitis A are rapidly reportable to the local health department</p>	<p>By the fecal-oral route through direct contact or ingestion of contaminated food or water.</p> <p>People with HAV infection are most infectious during the 1 to 2 weeks before onset of jaundice or elevation of liver enzymes, when concentration of virus in the stool is highest. Risk diminishes and is minimal by 1 week after onset of jaundice.</p>	<p>Initial symptoms begin abruptly and include fever, nausea, vomiting, anorexia, malaise, and abdominal pain or discomfort. Dark urine, pale stools, and jaundice (yellowing of the skin or eyes) might be present initially or might develop a few days to a week later. The likelihood of symptoms increases with age.</p> <p>Symptoms typically lasts less than 2</p>	<p>CASE: Cases with acute HAV infection who work as food handlers or attend or work in child care settings should be excluded for 1 week after onset of the illness. Serologic testing should be performed to confirm HAV infection in suspected cases. Exclusion until 1 week after onset of illness is indicated.</p> <p>CONTACTS: Determine if contact is immune to HAV through immunization records and/or serologic testing (a positive Hep A IgG). Contacts who are immune do not need additional follow-up. Determine if contact meets criteria for HAV post-exposure prophylaxis (PEP).</p>

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			months but can extend up to 6 months.	<p>Childcare staff or attendees who might have been exposed to HAV in the past 2 weeks should be excluded for 7 weeks after last contact with the case during the infectious period, unless they receive PEP within 14 days of exposure or report immunity through vaccination or serology indicating previous disease.</p> <p>Contacts who are symptomatic and epidemiologically-linked to a laboratory-confirmed case meet the case definition and should be managed as a case, including appropriate investigation and exclusion.</p> <p>In childcare center, stress importance of proper handwashing. In facilities with diapered children, if 1 or more cases confirmed in child or staff attendees or 2 or more cases in households of staff or attendees, hepatitis A PEP should be administered within 14 days of exposure to all unimmunized staff and attendees. In centers without diapered children, hepatitis A PEP should be administered only to unimmunized classroom contacts of index case. Asymptomatic contacts may return after receipt of hepatitis A PEP.</p> <p>If questions about management of cases and/or contacts, please contact local health dept.</p>
Hepatitis B*	From 45-160 days, average 90 days.	By direct contact with infected blood or body fluids. Transmission occurs when the hepatitis B virus enters the body through broken skin or mucous membranes. The risks of HBV acquisition when a susceptible child bites a child who has chronic HBV infection or when a susceptible child is bitten by a child with chronic HBV infection are unknown.	Developing symptoms of acute hepatitis are age-dependent. The spectrum of symptoms and signs is varied and includes subacute illness with nonspecific symptoms (e.g., anorexia, nausea, or malaise), clinical hepatitis with jaundice, or fulminant hepatitis.	<p>CASE: Follow advice of child's physician and/or your local health department.</p> <p>CONTACTS: School exclusion not indicated.</p>
HIV Infection* and AIDS* (Acquired Immunodeficiency Syndrome)	<p>Acute retroviral syndrome occurring in adolescents and adults following HIV acquisition occurs 7 to 14 days following viral acquisition and lasts for 5 to 7 days. Most patients are not ill enough to seek medical attention.</p> <p>The usual age of onset of symptoms is generally 12</p>	(1) sexual transmission (vaginal, anal, orogenital), (2) percutaneous blood exposure (e.g., contaminated needles), (3) mother-to-child transmission (MTCT), (4) mucous membrane exposure to contaminated blood or body fluids, (5) transfusion of contaminated blood or blood products, (6) cases of HIV transmission have been reported from contact of non-intact skin with blood-containing body	Clinical manifestations of untreated pediatric HIV infection include unexplained fevers, generalized lymphadenopathy, hepatomegaly, splenomegaly, failure to thrive, persistent oral and diaper candidiasis, recurrent diarrhea, parotitis, hepatitis, central nervous system (CNS) disease (e.g., encephalopathy, hyperreflexia, hypertonia, floppiness, developmental delay), lymphoid	<p>CASE: Follow advice of child's physician and/or your local health department.</p> <p>CONTACTS: School exclusion not indicated.</p>

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	to 18 months of age for untreated infants and children who acquire HIV infection through MTCT. Some children become ill in the first few months of life, but others remain relatively asymptomatic for more than 5 years and, rarely, until early adolescence.	fluids	interstitial pneumonia, recurrent invasive bacterial infections, and opportunistic infections (OIs) (e.g., viral, parasitic, and fungal infections).	
Influenza	Usually 1-4 days, with a mean of 2 days.	<p>Person-to-person by respiratory droplets created by coughing or sneezing. Another mode of transmission comes from contact with influenza virus from droplet-contaminated hands or surfaces, where it can remain for up to 24 hours, with transfer from hands to mucosal surfaces of the face. Airborne transmission via small-particle aerosols in the vicinity of the infectious individual also may occur.</p> <p>Patients may be infectious 24 hours before onset of symptoms. Viral shedding in nasal secretions usually peaks during the first 3 days of illness and ceases within 7 days but can be prolonged (10 days or longer) in young children and immunodeficient patients.</p>	Sudden onset of fever, often accompanied by nonproductive cough, chills or rigors, diffuse myalgia, headache, and malaise. Subsequently, respiratory tract symptoms, including sore throat, nasal congestion, rhinitis, and cough, become more prominent. Less commonly, abdominal pain, nausea, vomiting, and diarrhea are associated with influenza illness. In some children, influenza can appear as an upper respiratory tract illness or as a febrile illness with few respiratory tract symptoms. In infants, influenza can produce a nonspecific sepsis-like illness picture, and in infants and young children, influenza can cause otitis media, croup, pertussis like-illness, bronchiolitis, or pneumonia. Acute myositis secondary to influenza can present with calf tenderness and refusal to walk.	<p>CASE: Exclude from school until at least 24 hours following resolution of fever without the use of fever-reducing medication(s)</p> <p>CONTACTS: School exclusion not indicated.</p> <p>Annual seasonal influenza vaccination strongly encouraged to prevent cases of influenza or lessen severity of illness</p>
Measles* (Rubeola, Red Measles)	<p>Generally, 8-12 days from exposure to onset of symptoms. (Range of 7 to 21 days, average of 14 days between appearance of rash among case and contacts)</p> <p>All suspected or confirmed measles cases are rapidly reportable to</p>	<p>Direct contact with infectious droplets or by airborne spread through inhalation of infectious droplets when a person with measles coughs, sneezes, etc.</p> <p>Patients infected with wild-type measles virus are contagious from 4 days before the rash onset through 4 days after appearance of the rash.</p>	Characterized by fever, cough, coryza, and conjunctivitis, followed by a maculopapular rash beginning on the face and spreading cephalocaudally and centrifugally. During the prodromal period, a pathognomonic enanthem (Koplik spots) may be present. Sometimes the characteristic rash does not develop in immunocompromised patients.	<p>CASE: Exclude from school until at least 4 days after appearance of the rash and when the child is able to participate. Check immunization records of all students. People who have not been immunized, including those exempted from measles immunization for medical reasons, should be excluded from school, child care, and health care settings until at least 21 days after the onset of rash in the last case of measles. Discuss with your local health department. Every suspected measles case should be reported immediately to the local health department</p> <p>CONTACTS: Check immunization records of all contacts.</p>

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	the local health department		Koplik spots are typically 1-3mm whitish, grayish, or bluish elevations with an erythematous base typically seen on the buccal mucosa. Koplik spots are not seen in all measles cases.	Additional measures are not needed for children and/or staff who are fully vaccinated or have evidence of immunity to measles. People who have not been immunized, including those exempted from measles immunization for medical reasons, should be excluded from school, child care, and health care settings until at least 21 days after the onset of rash in the last case of measles. Discuss with your local health department. Every suspected measles case should be reported immediately to the local health department.
Meningitis, Bacterial (<i>H. influenzae</i> *, Meningococcal*, Pneumococcal)	In general, 1 to 10 days, usually less than 4 days. <i>H. influenzae</i> : 2-4 days Meningococcal: 2-10 days, usually 3-4 days. Pneumococcal: 1-4 days All suspected or confirmed cases of invasive <i>H. influenzae</i> disease or meningococcal disease are rapidly reportable to the local health department	Transmission occurs from person to person through droplets from the respiratory tract and requires close contact. Transmission can also occur by sharing beverages, utensils, and personal care products. Patients should be considered capable of transmitting the organism for up to 24 hours after initiation of effective antimicrobial treatment.	Typically, acute onset of fever, neck stiffness, neck pain, headache, light sensitivity and other neurologic symptoms or signs. In meningococcal disease, rash initially can be macular or maculopapular but typically becomes petechial or purpuric within hours. Signs and symptoms of meningococcal meningitis are sometimes indistinguishable from those associated with pneumococcal meningitis.	CASE: Exclude from school during acute illness. Non-communicable after 24-48 hours of appropriate drug therapy. CONTACTS: School exclusion not indicated. Discuss with your local health department to determine if close contacts need prophylactic treatment for <i>H. influenzae</i> or meningococcal meningitis. School students and staff should be advised not to share beverages, eating utensils, or personal care products.
Mumps*	From 12-25 days, usually 16-18 days. The recommended isolation period is 5 days after onset of parotid swelling. However, virus has been detected in patients' saliva as early as 7 days before and until 9 days after onset of swelling.	Mumps is highly infectious. Transmission occurs by droplet spread or by direct contact with respiratory tract secretions or the saliva of an infected person.	Fever with swelling and tenderness of one or both parotid glands as well as nonspecific symptoms such as muscle aches, loss of appetite, malaise, headache, and low-grade fever. Asymptomatic infection occurs in about 15-20% of cases, usually in adults more than children.	CASE: In addition to standard precautions, exclude from school for 5 days after the onset of parotid gland swelling. CONTACTS: Determination of vaccination status should be obtained for all contacts. In outbreak setting, consult local health department regarding outbreak management and whether contacts need to be excluded from school. If health department agrees, unimmunized contacts should be excluded until at least 26 days after onset of parotitis in the last person with mumps. Moreover, if the school is considered to be at high-risk for mumps, a recommendation may be made for students and staff who have had two doses of a mumps-containing vaccine to receive a third dose of MMR vaccine.
Norovirus	From 12-48 hours	Primarily by the fecal-oral route through direct contact or ingestion of contaminated food or water, or by touching contaminated surfaces. Transmission is also possible	Sudden onset of vomiting and/or diarrhea, abdominal cramps, and nausea. Symptoms typically last from 24 to 72 hours but prolonged illness can occur. Systemic	CASE: In addition to standard precautions, exclude from school until 48 hours after symptoms resolve. Stress importance of thorough handwashing as virus may be shed in stool for weeks after symptoms resolve.

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		through direct contact with the vomit, exposure to contaminated surfaces and aerosolized vomitus of an infected person.	manifestations, including fever, myalgia, malaise, anorexia, and headache, may accompany gastrointestinal tract symptoms.	CONTACTS: School exclusion not indicated. Environmental cleaning is a very important component of the response to a norovirus outbreak. A high-concentration bleach solution can be used—this solution must remain on the surface for enough time to kill norovirus. Surface must be rinsed with water to remove bleach residue.
Pediculosis (Head Lice)	Eggs hatch in about 1 week (range 6-9 days), and reach maturity to an adult about 7 days later.	By direct head-to-head contact with hair of an infected person. Transmission can occur by the personal belongings of an infected person, but this is uncommon. Head lice occurs most commonly in children attending child care, preschool, and elementary school, and is not a sign of poor hygiene.	Severe itching and scratching, often with secondary infection. Eggs of head lice (nits) attach to hairs as small, round, gray lumps. However, many children are asymptomatic. Excoriations and crusting caused by secondary bacterial infection may occur.	CASE: Notify parents; inform that child has lice and should be treated. Children should not be excluded or sent home early from school because of head lice, because head lice have a low contagion within classrooms. “No-nit” policies should be discouraged for cases. CONTACTS: Household and close contacts should be examined and treated if infested. No exclusion necessary. Routine classroom or school-wide screening for lice is discouraged. Parents who are educated on the diagnosis of lice infestation may screen their own children’s heads for lice regularly and if the child is symptomatic. Refer for treatment if infested.
Pertussis* (Whooping Cough)	From 5-21 days, usually 7-10 days. All suspected or confirmed cases of pertussis are rapidly reportable to the local health department	By direct contact with large respiratory droplets (coughing, sneezing) of an infected person by the airborne route.	The initial stage begins with mild upper respiratory symptoms of a common cold and increasingly irritating cough. The paroxysmal stage usually follows within 1 to 2 weeks. “Classic” pertussis has a duration of about 6-10 weeks. Paroxysmal stage is characterized by repeated episodes of violent cough broken by a high-pitched inspiratory whoop and vomiting. Older children may not have whoop. Convalescence may require many weeks.	CASE: Exclude from school until 5 days after initiation of appropriate antibiotic therapy. A 5-day course of azithromycin is usually treatment of choice, and is also used for post-exposure prophylaxis. Untreated individuals should be excluded until 21 days have elapsed from cough onset. If questions about pertussis treatment or post-exposure prophylaxis, discuss with your local health department. CONTACTS: Individuals in all settings who have been in close contact with a person infected with pertussis should be monitored closely for respiratory tract symptoms for 21 days after last contact with the infected person. Close contacts with cough should have medical evaluation. Exclude on first indication of symptoms pending physician evaluation.
Ringworm of the Body (Tinea Corporis)	Incubation period believed to be 1 to 3 weeks but can be shorter, as reported cases have occurred at 3 days of age.	By contact with lesions of an infected persons, animals, soil or fomites (e.g., brushes, combs, hats, towels).	Circular, red to brown, well-demarcated lesion that can involve face, trunk, or limbs. The classic eruption displays a scaly, vesicular, or pustular border (often serpiginous) with central clearing. Small confluent plaques or papules as well as multiple lesions can occur. Itching is common.	CASE: Exclusion from school not indicated as long as lesions are covered or child is receiving treatment. CONTACTS: School exclusion is not indicated.
Rubella*	From 12 to 23 days,	By direct contact or droplet spread	Mild symptoms; slight fever, rash of	CASE: Exclude from school for 7 days after onset of rash. Avoid

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(German Measles)	usually 17 days. All suspected or confirmed cases of rubella are rapidly reportable to the local health department	of nasopharyngeal secretions of an infected person. People infected with rubella are most contagious when the rash is erupting.	variable character lasting about 3 days; enlarged head and neck lymph glands common lasting between 5 to 8 days. Joint pain may occur, especially in older children and adults. Communicable for 7 days before onset of rash and at least 7 days thereafter.	exposure to women in early pregnancy. Check immunization records of all students. Discuss with your local health department. CONTACTS: In outbreak setting, children without evidence of immunity should be immunized or excluded for 21 days after onset of rash of the last case in the outbreak. Pregnant contacts should be evaluated.
Scabies	Persons without previous exposure: 4 to 6 weeks. Previously infested and sensitized: 1-4 days after re-exposure.	By direct skin-to-skin contact, usually prolonged exposure. Infection from dogs or other animals is uncommon. Casual skin contact unlikely to result in transmission. Fomite transmission not likely to lead to classic scabies, but fomite transmission more likely in setting of crusted scabies since parasite burden is much higher.	Begins as itchy raised areas around finger webs, wrists, elbows, armpits, belt-line, thighs, naval, abdomen, buttocks and/or genitalia. In older children and adults, in areas such as the scalp, face, neck, palms, and soles. Scabitic burrows appear as thin, gray or white, serpiginous, thread-like lines Extensive scratching often results in secondary infection. Crusted scabies (also known as Norwegian scabies) can occur in people who have deficiency in cellular immunity (AIDS, lymphoma, long-term steroid use, etc.).	CASE: Exclude from school until after the first course of appropriate treatment has been completed. Children should not be excluded or sent home early from school because scabies has a low contagion within classrooms. CONTACTS: Close contacts with prolonged skin-to-skin contact should receive treatment at the same time the infected person does. Bedding and clothing in contact with skin of infected people should be laundered.
Streptococcal Diseases (Including Impetigo, Scarlet Fever, and Streptococcal pharyngitis)	Some common Group A Streptococcal infections include (1) impetigo, (2) streptococcal pharyngitis ("strep" throat) and (3) Scarlet fever. Typical incubation periods are as follows: Impetigo: 7-10 days Streptococcal pharyngitis: 2-5 days Scarlet fever: generally occurs in conjunction with streptococcal pharyngitis	In impetigo, usually acquired by direct contact with skin lesions or their discharge from an infected person. Strep pharyngitis/Scarlet fever: By direct contact with infected persons and carriers or by contact with their respiratory droplets.	Impetigo: Multiple skin lesions usually of exposed area (e.g., elbows, legs, and knees), but may involve any area. Lesions vary in size and shape, and begin as blisters, which rapidly mature into brown crusts on a reddened base. Healing from center outward produces circular areas, which may resemble ringworm. Scarlet Fever: Fever, sore throat, exudative tonsillitis or pharyngitis. Sandpaper-like rash appears most often on neck, chest, and skin folds of arms, elbows, groin, and inner aspect of thighs. "Strep" throat: Sudden onset of fever, sore throat, exudative tonsillitis or pharyngitis, and enlarged lymph nodes. Symptoms	CASE: For impetigo: Exclude from school until lesions are healed or until at least 12 hours after antibiotic treatment has been started. Close contact with other children should be avoided during this time. For Group A strep pharyngitis: Exclude from school until 12 hours after appropriate antibiotic therapy has been started CONTACTS: For impetigo: Exclusion from school not indicated. Stress good handwashing. For Group A Strep pharyngitis: Symptomatic contacts of a child with documented Group A Strep infection with recent or current clinical evidence of a Group A Strep infection should be medically evaluated and treated if positive. Routine lab testing or school exclusion of asymptomatic household contacts is not indicated except during outbreaks or if the contact is at high-risk of developing sequelae of infection. In general, in the school setting, chemoprophylaxis against Group A Strep is not recommended.

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