

COMMUNICABLE DISEASE RESOURCE GUIDE

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This Resource Guide can be found in the full-text version at:

<http://azdhs.gov/phs/owch/publications/index.php>



COMMUNICABLE DISEASE RESOURCE GUIDE

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SECTION I

SECTION I

OUR MISSION

The mission of Arizona Department of Health Services is “To promote, protect, and improve the health and wellness of individuals and communities in Arizona”

The original Communicable Disease Resource Guide was prepared jointly by Arizona Department of Health Services, Bureau of Women’s and Children’s Health (ADHS/BWCH); and by Maricopa and Pima County Public Health Departments. Currently, Pima County Health Department, Public Health Nursing with the support of ADHS/BWCH is responsible for managing the Resource Guide. This resource is designed for use as a reference guide for individuals who are responsible for the health and safety of children in group settings. These individuals may be school nurses, child care health consultants (CCHCs), child care providers, crisis nursery staff, children’s camp personnel, lay health workers or parents. The information in this Resource Guide is not meant to replace consultation with a health care provider regarding the health status or treatment needs of individual children. It may be used for general information and as a reference guide for developing policies for the group setting.

The content has been compiled from many resources and is consistent with *Arizona Communicable Disease Rules and Regulations* and *Caring for Our Children: National Out-of-Home Child Care Standards* (<http://nrckids.org/CFOC3/index.html>), developed by the American Public Health Association and the American Academy of Pediatrics. Arizona child care rules and regulations for centers, group homes and family child care homes, were also considered in preparing this document.

Special thanks to Teresa Ehnert, Bureau Chief, Emergency Preparedness, Arizona Department of Health Services and Cara Christ, MD MS, Chief Medical Officer at Arizona Department of Health Services for review and editing of this resource.

HOW TO USE THIS RESOURCE GUIDE:



- Each disease is briefly described in alphabetical order.
- A glossary is located in Section IV. All words or terms which are in **blue bold** (darker) type can be found in the glossary.
- Disease reporting requirements included here are consistent with Arizona Administrative Rules for schools and child care centers.

Reporting information for schools and child care programs is found at:

http://www.azdhs.gov/phs/oids/pdf/rptlist_schools.pdf

Health care providers’ reporting information is found at <http://www.azdhs.gov/phs/oids/reporting/providers.htm>

- Additionally, visual prompts for reporting are included in the header for reportable diseases:

-  = Report immediately (within 24 hours) by telephone
-  = Submit a written report within 5 working days
- O** = Submit report within 24 hours of detecting an **outbreak**

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SECTION I

HEALTH DEPARTMENTS

Apache County Health Dept.

P.O. Box 697
St. Johns, AZ 85936
(928) 337-4364

Cochise County Health Dept.

1415 W. Melody Lane, Bldg. A
Bisbee, AZ 85603
(520) 432-9400

Disease Reports: (520) 432-9435

Coconino County Health Dept.

2625 N. King St.
Flagstaff, AZ 86004
(928) 679-7272

Fort Yuma PHS Indian Hospital

P.O. Box 1368
Yuma, AZ 85364
(760) 572-0217

Gila County Health Dept.

5515 S. Apache Ave., Suite 100
Globe, AZ 85501
(928) 425-3189

Gila River Healthcare/Hu Hu Kam

Memorial Hospital 483

483 W. Seed Farm Rd.
Sacaton, AZ 85247
(520) 562-3321 (Local)
(602) 528-1350 (Phoenix)

Graham County Health Dept

826 W. Main Street
Safford, AZ 85546
(928) 428-1962 or
(928) 428-0110

Greenlee County Health Dept.

P.O. Box 936
253 5th Street
Clifton, AZ 85533
(928) 865-2601

Keams Canyon PHS Indian Hosp

1 Main Street
Keams Canyon, AZ 86034
(928) 738-5252

La Paz County Health Dept.

1112 Joshua St., #206
Parker, AZ 85344
(928) 669-1100

Maricopa County Department of Public Health

4041 N. Central Ave. Suite 1400
Phoenix, AZ 85012
(602) 506-6900

Immunizations: (602) 506-6767

Mohave County Health Dept.

700 W. Beale Street
Kingman, AZ 86401
(928) 753-0743

Navajo Area Indian Health Service

P.O. Box 9020
Window Rock, AZ 86515
(928) 871-5811

Navajo County Health Dept.

117 E. Buffalo
Holbrook, AZ 86025
(928) 524-4750

Showlow Clinic: (928) 532-6050

Pima County Health Dept

3950 S. Country Club Rd.
Tucson, AZ 85714
Disease Reports: (520) 243-7797
Immunizations: (520) 243-7988

Pinal County Division of Public Health

P.O. Box 2945
971 Jason Lopez Circle Bldg. D
Florence, AZ 85132
Disease Reports: (520) 866-7325
Immunizations: 1-866-960-0633

San Carlos PHS Indian Hosp

P.O. Box 208
San Carlos, Arizona 85550
(928) 475-2371

Santa Cruz County Health Dept.

P.O. Box 1150
Nogales, AZ 85621
(520) 375-7900

San Xavier Indian Health Center

7900 South J Stock Road
Tucson, AZ 85746
(520) 295-2550

Whiteriver PHS Indian Hospital

P.O. Box 860
Whiteriver, AZ 85941
(928) 338-4911

Yavapai County Community Health Services

1090 Commerce Drive
Prescott, AZ 86305
(928) 771-3134
Immunizations: (928) 442-5286

Yuma County Health Dept

2200 W. 28th St.
Yuma, AZ 85364
(520) 317-4550

Indian Health Services

40 N. Central Avenue #505
Phoenix, AZ 85004
(602) 364-5039

AZ Dept of Health Services




150 N. 18th Avenue
Phoenix, AZ 85007
Immunization Program:
(602) 364-3630
**Epidemiology and Disease
Control:** (602) 364-3860

SECTION I

ARIZONA ADMINISTRATIVE CODE* REQUIRES AN ADMINISTRATOR OF A SCHOOL, CHILD CARE ESTABLISHMENT, OR SHELTER TO: **REPORT COMMUNICABLE DISEASES** TO THE LOCAL HEALTH DEPARTMENT

-  Campylobacteriosis
 -  Conjunctivitis: Acute
 -  Cryptosporidiosis
 -  Diarrhea, Nausea, or Vomiting
 -  Enterohemorrhagic *Escherichia coli*
 -  *Haemophilus influenzae* : Invasive Disease
 -  Hepatitis A
 -  Measles
 -  Meningococcal Invasive Disease
 -  Mumps
 -  Pertussis (Whooping Cough)
 -  Rubella (German Measles)
 -  Salmonellosis
 -  Scabies
 -  Shigellosis
 -  Streptococcal Group A Infection
 -  Varicella (Chickenpox)
-

KEY

-  Submit a report within 24 hours after detecting a case or suspect case.
-  Submit a report within 24 hours after detecting an outbreak.
-  Submit a report within five working days after detecting a case or suspect case.

*A.A.C. R9-6-203
Effective December 31, 2009



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SECTION I

THE COMMUNICABLE DISEASE REPORT FORM IS AVAILABLE ON THE INTERNET AT:

http://www.azdhs.gov/phs/oids/pdf/forms/cdr_form.pdf

The format allows for convenient electronic completion.

**Arizona Department of Health Services
Office of Infectious Disease Services**

150 N. 18th Avenue, Suite 140

Phoenix, AZ 85007

(602) 364-3676

(602) 364-3199 Fax

After Hours Emergency Calls

(480) 303-1191



COMMUNICABLE DISEASE REPORT

Important Instructions: Please complete sections 1-3 for all reportable conditions. In addition, complete Section 4 for STDs and HIV/AIDS cases, Section 5 for hepatitis, and Section 6 for tuberculosis. Once completed, return to your county or tribal health agency. If reporting through MEDSIS, go to <https://my.health.azdhs.gov/>.

County / IHS Number	State ID / MEDSIS ID	Date Received by County
---------------------	----------------------	-------------------------

1. PATIENT INFORMATION

Patient's Name (Last, First, Middle)	Date of Birth	Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Pregnant: <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes Due date _____	
Street Address:	City:	State:	Zip code:	County:	Reservation:	Telephone#:
Patient's Occupation or School:	Guardian: (not necessary for STD)	Outcome: <input type="checkbox"/> Survived <input type="checkbox"/> Died Date: _____	Is the patient any of the following? <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Food worker/handler <input type="checkbox"/> School or childcare worker or attendee Facility Name & Address: _____			

2. REPORTABLE CONDITION INFORMATION / LAB RESULTS

Diagnosis or Suspect Reportable Condition	Onset Date	Diagnosis Date
LAB RESULTS	Date Collected	Date Finalized
	Specimen Type <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> NP Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____	Lab Test
	Lab Result	

3. REPORTER & PROVIDER INFORMATION

Reporting Source (Physician or other reporting source)	Facility			
Street Address	City	State	Zip code	Telephone#
Provider (if different from Reporter)	Facility			
Provider Street Address	City	State	Zip code	Telephone#
Laboratory Name, Address and Telephone#				

4. SEXUALLY TRANSMITTED DISEASES (STD) AND HIV/AIDS

Diagnosis			
<input type="checkbox"/> Syphilis (specify below) <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Early Latent (<1 year) <input type="checkbox"/> Late (> 1 year) <input type="checkbox"/> Congenital Mother's Name: _____ Mother's DOB: _____ <input type="checkbox"/> Other Syphilis _____ <input type="checkbox"/> Neurological symptoms: _____	<input type="checkbox"/> Chlamydia <input type="checkbox"/> PID <input type="checkbox"/> Gonorrhea <input type="checkbox"/> PID <input type="checkbox"/> Herpes <input type="checkbox"/> Chancroid	<input type="checkbox"/> HIV/AIDS Risk Factors <input type="checkbox"/> IDU <input type="checkbox"/> Sex with IDU <input type="checkbox"/> Sex with males Date of Last Negative HIV Test: _____	Site of Infection <input type="checkbox"/> Genitalia <input type="checkbox"/> Rectum <input type="checkbox"/> Throat <input type="checkbox"/> Other Patient had Sexual Contact with: <input type="checkbox"/> Males only <input type="checkbox"/> Refused <input type="checkbox"/> Females only <input type="checkbox"/> Unknown <input type="checkbox"/> Both Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic partner Sex Partners: # Sex partners _____ # Sex partners treated _____
Treatment			
Date	Drug	Dosage	
Date	Drug	Dosage	
Date	Drug	Dosage	

5. HEPATITIS PANEL

Hepatitis A Serology Results	Hepatitis A Antibody (acute IgM anti-HAV)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
Hepatitis B Serology Results	Hepatitis B surface Antigen (HBsAg)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
	Hepatitis B core Antibody IgM (HBcAb-IgM)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
	Hepatitis B core Antibody Total (HBcAb)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
	Hepatitis B surface Antibody (HBsAb)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
	Hepatitis B e Antigen (HBeAg)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
	Symptoms consistent with acute hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Liver Function Test ALT: _____	AST: _____
Hepatitis C Serology Results	Hepatitis C-EIA	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
	Hepatitis C-RIBA	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
	Hepatitis C-NAT/PCR	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
	Hepatitis C-Viral Load	_____
	Liver Function Test ALT: _____	AST: _____

6. TUBERCULOSIS (TB)

Site of Disease	<input type="checkbox"/> Pulmonary <input type="checkbox"/> Laryngeal <input type="checkbox"/> Extrapulmonary
<input type="checkbox"/> TB Infection in a Child 5 and Under (Positive TB skin test result)	
Medicine and Dosage	



VARICELLA (CHICKENPOX) REPORTING FORM

School-based Varicella Sentinel Surveillance System

For **schools and child care facilities** for reporting of **chickenpox ONLY**

School or Child Care reporting _____

Person reporting _____ Phone _____

Date of report _____

Name of Child	Date of Birth	Date of Onset	Received Varicella Vaccine?	Date(s) Vaccinated	Grade of Lesions*
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III
			Y N		I II III

***Grade of lesions:** Estimated number of chickenpox lesions/spots easily counted by parent or nurse.

Grade I: 50 spots or less easily counted within 30 seconds

Grade II: 50–500 spots (between Grades I and III)

Grade III: 500 or more spots, or spots clumped so close together that little normal skin is visible

Please send monthly to your county health department[†], even if you have no cases to report.

[†]Pima County Health Department requests phone calls from Pima County schools and child care programs to report even single cases of chickenpox (520) 243-7988

SECTION II

SECTION II—ANIMAL BITES

**IMMEDIATE INTERVENTION:**

Wash all bites and scratches with soap and water. Refer the individual immediately to a health care provider, emergency care facility, or local health department to determine if anti-rabies treatment is needed.

REPORTS REQUIRED:

All bites from animals, or contact with bats or other wild animals should be reported immediately to local animal control or the local health department.

SPECIAL FEATURES:

The individual's **immunization** history will be checked by the health care provider to determine if a “booster” dose for tetanus is required.

Children under the age of seven may receive diphtheria, tetanus and pertussis (DTaP) vaccine or diphtheria and tetanus (DT) vaccine. After the age of seven, an adult vaccine containing tetanus and diphtheria (Td or Tdap) is given.

Rabies **immune globulin** and rabies vaccine may be recommended. Administration of tetanus **immune globulin** (TIG) may be considered for some individuals.

PREVENTION:

In Arizona, the overwhelming majority of rabies occurs in wildlife including skunks, foxes, coyotes, bats, raccoons, javelinas, and bobcats. Small rodents are not considered a rabies risk in Arizona.

Teach children not to pick up, touch, or feed wild or unfamiliar animals, especially sick or wounded ones. If you find a bat on the playground, don't touch it. Place a box over the bat to contain it. Keep children away. Be careful not to damage the bat in any way.

Report the bat and animal bites including where the animal is to the local animal control officer or health department.

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Rabies information: <http://www.cdc.gov/rabies/>

Rabies for Kids: <http://www.cdc.gov/rabiesandkids/>

Information on Bats and Rabies at School: <http://www.azdhs.gov/phs/oids/vector/rabies/bats-at-schools/index.htm>

Arizona Department of Health Services: <http://www.azdhs.gov/phs/oids/vector/rabies/>

SECTION II—CHICKENPOX



(VARICELLA)

SIGNS AND SYMPTOMS:

Mild **fever**, **listlessness**, a rash that can be seen and felt, and then appears as small fluid-filled blisters (vesicles) for 3–4 days. The blisters break and then scab over. Several stages may be present at the same time.

IMMEDIATE INTERVENTION:

Isolate the individual and exclude.

INCUBATION PERIOD:

Commonly 14–16 days; some **cases** occur as early as 10 days and as late as 21 days after contact.

CONTAGIOUS PERIOD:

Two days before blisters appear until all blisters have dry, complete scabs.

TRANSMISSION:

Spread by **secretions** from the nose, eyes, mouth and throat of an infected individual. These **secretions** may be on surfaces or in infected droplets in the air. Also spread by direct spread by contact with the fluid in the blisters or items contaminated with the fluid. Also dry scabs are not infective.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until all blisters are scabbed over and dry, and the individual is **fever-free for 24 hours without the use of fever-reducing medications**.

Contacts: No restrictions.

PREGNANT CONTACTS:

Pregnant women exposed to chickenpox, should contact their health care provider as soon as possible.

REPORTS REQUIRED:

Written Case reports are required within 5 days. Schools and child care programs must report the occurrence or absence of chickenpox on a monthly basis. The Varicella (Chickenpox) Reporting form is found in Section 1 of this Resource Guide. It may be copied for use and submitted by mail, fax or electronically to the local health department.

SPECIAL FEATURES:

Chickenpox, also called varicella, is a highly contagious, but not usually serious, disease caused by a herpes virus. Varicella tends to be more severe in adolescents and adults than in young children. Mild **cases** of chickenpox can occur in immunized children.

Individuals with chickenpox should not take aspirin. Non-aspirin products may be used for **fever**-reduction. The use of aspirin has been associated with **Reye's Syndrome**.

Use of creams or lotions containing diphenhydramine is not recommended, unless prescribed by a health care provider.

SECTION II—CHICKENPOX



(VARICELLA)

Shingles (herpes zoster) is a recurrence of a previous infection with chickenpox virus which is often associated with aging or a weakened immune system. Do not exclude individuals with shingles if blisters can be covered completely with clothing, or a bandage. Keep covered until blisters are scabbed over and dry. A vaccine to help reduce the risk of developing shingles in individuals age 50 and over is available. A health care provider can supply additional information.

Individuals exposed to varicella zoster virus who do not have evidence of immunity to varicella and are at high risk for infection and complications may receive a varicella zoster immune globulin preparation to lower the risk of severe infections.

Children's recommended immunization schedules include varicella vaccine given at 12 to 15 months of age with a second dose routinely between the ages of 4 and 6 years. During a community outbreak, a second dose may be given as soon as three months after the first dose. Individuals age 13 and over (including adults) may receive 2 doses of varicella vaccine separated by at least 4 weeks.

It is possible, although rare, for children to get chickenpox a second time. It is also possible for vaccinated individuals to get chickenpox. In both cases the disease is usually less severe, and the rash may lack the blister-like appearance.

See Handwashing, Infection, Control Measures, Immunization Schedules, Rash Flow Chart, Features of Rash Illness, and Parent Alert Letter.

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Chickenpox information: <http://www.cdc.gov/vaccines/vpd-vac/varicella/>

National Network for Immunization information: <http://www.immunizationinfo.org/vaccines/varicella-chickenpox>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding): <http://www.mothertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION II—CONJUNCTIVITIS

O

(PINK EYE)

SIGNS AND SYMPTOMS:

Watering, irritation, and redness of the white part of the eye and/or the lining of the eyelids. Swelling of the eyelids, crusting of the eyelids or lashes, sensitivity to light, and a pus-like discharge may occur.

IMMEDIATE INTERVENTION:

Refer to a health care provider for diagnosis and possible treatment.

INCUBATION PERIOD:

Unknown

CONTAGIOUS PERIOD:

Viral: From the onset of **signs** and **symptoms**, and while the eye is still red and draining.

Bacterial: Up to 24 hours after antibiotics are started. Without treatment, from the onset of **signs** and **symptoms**, and while the eye is still red and draining.

TRANSMISSION:

Direct contact with the discharge from the eyes or items soiled with discharge.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude if the child has uncontrolled drainage from the eyes or is uncomfortable

Contacts: No restrictions.

REPORTS REQUIRED:

Individual reports are not required. If more than one case, notify the local health department within 24 hours for reporting requirements and additional management steps.

SPECIAL FEATURES:

Individuals should not to share linens, towels, wash cloths or eye make-up.

Careful handwashing after contact with discharge from the eyes or articles soiled with the discharge is necessary. Throw away all tissues immediately after one use. Use face cloths one time and on only one individual before laundering.

Viral conjunctivitis, unlike bacterial conjunctivitis, will not respond to **antibiotic** treatment and the **signs**, **symptoms** and **contagious period** may be prolonged.

See Handwashing, Infection Control Measures, and Parent Alert Letter.



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SECTION II—CONJUNCTIVITIS

O

(PINK EYE)



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

Mayoclinic.com: <http://www.mayoclinic.com/health/pink-eye/DS00258>

WebMD: <http://www.webmd.com/eye-health/eye-health-conjunctivitis>

SECTION II—CYTOMEGALOVIRUS

(CMV)

SIGNS AND SYMPTOMS:

Often no apparent symptoms. **Fever**, sore throat, **listlessness**, swollen lymph nodes may be present. Swelling of the spleen or abdomen and a skin rash are less common symptoms. **Jaundice** occurs rarely.

IMMEDIATE INTERVENTION:

None.

INCUBATION PERIOD:

From 3–8 weeks, or 3–12 weeks for infections acquired during birth.

CONTAGIOUS PERIOD:

Young children infected with CMV may excrete the virus in their stool, urine and **secretions** from the nose and mouth intermittently from months to years.

TRANSMISSION:

Direct contact with infected mouth or nose **secretions**, breast milk, urine, cervical **secretions** or semen.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: No restrictions.

Contacts: No restrictions.

Pregnant Contacts: CMV can cause stillbirth and birth defects in rare cases when a woman develops a first CMV infection during pregnancy. Many women have already been exposed to CMV and are not at risk of a new infection during their pregnancy. Because young children are more likely to have CMV in their urine or saliva and other body secretions than are older children or adults, pregnant women (or women who may become pregnant) who work with young children should discuss the risk of CMV with their health care provider.

REPORTS REQUIRED:

None required.

SPECIAL FEATURES:

Care in handling diapers and all items contaminated with body secretions is essential. Use careful handwashing, sanitation, and diapering practices. Provide special attention to sanitation of mouthed toys throughout the day. Blood tests are available to determine if an individual is susceptible to CMV.

See Handwashing, Infection Control Measures.

SECTION II—CYTOMEGALOVIRUS

(CMV)



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Cytomegalovirus information: <http://www.cdc.gov/cmv/index.html>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding): <http://www.mothersbaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

Diaper Changing Procedures: Caring for Our Children: National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, 3rd Edition: <http://cfoc.nrckids.org/StandardView/3.2.1.4>

SECTION II—DIARRHEAL DISEASES

STAPHYLOCOCCAL FOOD POISONING

SIGNS/SYMPTOMS:

Nausea, cramps, vomiting, diarrhea

INCUBATION PERIOD:

1–6 hours

CONTAGIOUS PERIOD:

Not contagious person to person

TRANSMISSION:

Food or hands contaminated with toxins; storing food at room temperature

SCHOOL/CHILD CARE ATTENDANCE:

Exclude until no symptoms are present*

SALMONELLA

SIGNS/SYMPTOMS:

Diarrhea, cramps, fever, vomiting, headache

INCUBATION PERIOD:

6–36 hours

CONTAGIOUS PERIOD:

Throughout infection; several days to several weeks*

TRANSMISSION:

Swallowing bacteria via food, water, or mouthed items; highly infectious person-to-person

SCHOOL/CHILD CARE ATTENDANCE:

Exclude until no symptoms are present*

SHIGELLA (SHIGELLOSIS)

SIGNS/SYMPTOMS:

Cramps, vomiting, diarrhea, bloody stool, headache, nausea, fever

INCUBATION PERIOD:

1–3 days

CONTAGIOUS PERIOD:

Throughout infection; up to 4 weeks without treatment; 1 week with treatment

SECTION II—DIARRHEAL DISEASES

TRANSMISSION:

Swallowing bacteria via food, water, or mouthed items; indirectly from infected hands

SCHOOL/CHILD CARE ATTENDANCE:

Exclude until no symptoms are present and antibiotics are started*

CAMPYLOBACTER



SIGNS/SYMPTOMS:

Cramps, diarrhea, bloody stool, fever

INCUBATION PERIOD:

3–5 days

CONTAGIOUS PERIOD:

Throughout infection; 2–7 weeks without treatment; 2–3 weeks with treatment

TRANSMISSION:

Swallowing of bacteria via food, water, or mouthed items; indirectly from infected hands

SCHOOL/CHILD CARE ATTENDANCE:

Exclude until no symptoms are present or until on antibiotics for at least 2 days*

AMEBIASIS

SIGNS/SYMPTOMS:

No symptoms to fever, chills, diarrhea, blood in stool

INCUBATION PERIOD:

2–4 months to years

CONTAGIOUS PERIOD:

Throughout infection; can be infectious for years without treatment

TRANSMISSION:

Swallowing of parasite via food, water, or mouthed items; indirectly from infected hands

SCHOOL/CHILD CARE ATTENDANCE:

Exclude while symptoms are present*

GIARDIA (GIARDIASIS)*



SIGNS/SYMPTOMS:

May have no symptoms; may see chronic diarrhea to intermediate diarrhea; may have gas, bloating, foul smelling stool, blood in stool

SECTION II—DIARRHEAL DISEASES

INCUBATION PERIOD:

6–10 days

CONTAGIOUS PERIOD:

Throughout infection; months to years without treatment

TRANSMISSION:

Swallowing of parasite via food, water, or mouthed items; indirectly from infected hands

SCHOOL/CHILD CARE ATTENDANCE:

Exclude until no symptoms are present*

SHIGA TOXIN-PRODUCING E COLI (O157:H7)

SIGNS/SYMPTOMS:

Diarrhea, abdominal pain, nausea, fever, vomiting, bloody stool

INCUBATION PERIOD:

1–7 days; average 4 days

CONTAGIOUS PERIOD:

Throughout infection

TRANSMISSION:

Eating raw or under-cooked meat; via infected water; indirectly from infected hands

SCHOOL/CHILD CARE ATTENDANCE:

Exclude until no symptoms are present*

NOROVIRUS

See Resource Guide pages 53

*Call the local health department for management steps when a food handler has a diarrheal disease. A food handler is “anyone involved in the preparation, service, or storage of food.”

SCHOOL/CHILD CARE ATTENDANCE:

Cases: It must be assumed that undiagnosed loose, watery, unformed or frequent stools especially if accompanied by nausea, vomiting, fever, or cramping are caused by a contagious germ. These individuals must be excluded until they have been symptom-free for 24 hours.

Contacts: No restrictions if diarrhea is not present.

SECTION II—DIARRHEAL DISEASES

REPORTS REQUIRED:

For school and child care, immediate telephone reports of cases or suspect cases are required for Salmonella, Shigella and Shiga toxin-producing E. Coli (O157:H7). Campylobacter cases or suspect cases should be reported within 5 days by written Communicable Disease Reporting Form. See http://www.azdhs.gov/phs/oids/pdf/forms/cdr_form.pdf Health care providers must also report Amebiasis, and Giardia infections.

Food handlers have an increased risk of spreading diarrheal diseases. Always contact the local health department for management steps if food handlers have a diarrheal disease. A food handler is “anyone involved in the preparation, service or storage of food.”

SPECIAL FEATURES:

Diarrheal diseases are caused by germs (bacteria, parasites, viruses) that multiply in the intestines and are spread out of the body in the stool. Anyone can get diarrheal diseases and they can be infected multiple times. Laboratory tests are the only way to tell if a stool contains a specific germ that requires special treatment.

There can be non-contagious causes for occasional episodes of diarrhea such as taking antibiotics, new foods, or stress. This diarrhea usually clears up when the new food is discontinued or the **antibiotic** is completed.

In the group setting stress handwashing, sanitizing practices, and appropriate soiled-diaper management to prevent the spread of diarrheal diseases.

See Handwashing, Infection Control Measures, and Parent Alert Letter.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

Arizona Department of Health Services Communicable Disease Reporting Form:

http://www.azdhs.gov/phs/oids/pdf/forms/cdr_form.pdf

CDC Diseases and Conditions: <http://www.cdc.gov/DiseasesConditions/> (Search diseases by name)

Diaper Changing Procedures: Caring for Our Children: National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, 3rd Edition: <http://cfoc.nrckids.org/StandardView/3.2.1.4>

SECTION II—FIFTH DISEASE

SIGNS AND SYMPTOMS:

May be mild: Low fever, headache, body ache, nausea or chills for 2–3 days. About a week later a rash appears beginning with bright-redness of the cheeks (slapped cheek appearance). The cheeks are hot but not painful. There may also be scattered red raised spots on the chin, forehead and behind the ears. Approximately 1 day later a lace-like rash spreads to upper arms and legs, and sometimes the trunk. This lacy rash may disappear and then reappear over a period of weeks, particularly after exposure to sunlight, extreme heat or cold. Adults may not develop the rash but may experience aching in the joints particularly at the wrist and knees.

IMMEDIATE INTERVENTION:

Exclude all individuals who have fever. Call the local health department immediately to report all rashes accompanied by fever.

INCUBATION PERIOD:

Usually 4–14 days, but as long as 21 days.

CONTAGIOUS PERIOD:

Before the appearance of the rash during the mild symptoms.

TRANSMISSION:

Contact with **secretions** from the nose, mouth and throat of an infected person. The **secretions** may be on surfaces or in infected droplets in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude all individuals with undiagnosed fever and rash until fever-free for 24 hours without the use of fever-reducing medications. Fever-free individuals diagnosed with Fifth disease may return to the group setting although a rash may still be present.

Contacts: No restrictions.

REPORTS REQUIRED:

None. If there is an unusual absentee rate (above 10% of individuals in a single group setting) with Fifth Disease, notify the local health department for additional management steps.

SPECIAL FEATURES:

Most cases occur in the late winter and early spring. Fifth Disease is caused by human Parvovirus B19. Outbreaks of this illness among children in child care and elementary school are not unusual.

Many people have already had Fifth Disease before reaching young adulthood. It is estimated that half the adults in the United States are immune because of previous infection.

In rare situations, miscarriages and stillbirths have been associated with Fifth Disease during pregnancy. If pregnant and working with young children, the pregnant woman should inform her health care provider of potential exposure to Fifth Disease infection. Blood tests are available to determine if an individual is susceptible to Parvovirus B19.

There is no treatment for Fifth Disease.

See Handwashing, Infection Control Measures, Features of Rash Illness, and Parent Alert Letter.

SECTION II—FIFTH DISEASE



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Fifth Disease information: <http://www.cdc.gov/parvovirusB19/fifth-disease.html>

Fifth Disease Organization <http://www.fifthdisease.org/>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding): <http://www.mohtertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION II—GIARDIASIS



SIGNS AND SYMPTOMS:

Often occurs without symptoms. A variety of diarrhea symptoms may be present including frequent loose, watery (or unfirmed) stools. Stools may be foul-smelling and accompanied by cramping and gas.

IMMEDIATE INTERVENTION:

If symptomatic, exclude and refer to a health care provider for specific stool examination and treatment.

INCUBATION PERIOD:

From 1–4 weeks; average 2 weeks.

CONTAGIOUS PERIOD:

As long as the **protozoan** is present in the stool.

TRANSMISSION:

Stool-to-mouth (fecal-oral) by way of unwashed hands, or food contaminated by unwashed hands. Often transmitted in the child care setting among diapered children. Drinking untreated water from lakes or streams.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: All individuals with **diarrhea** should be excluded. If laboratory studies confirm the presence of giardia, the individual should be excluded from the group setting until 24 hours after appropriate treatment has been initiated and the individual has no **diarrhea**, cramping or **fever**.

Contacts: Contacts may not perform food handling duties, or care for children in child care programs, if **signs** and **symptoms** of giardia infection are present.

Screening of other **contacts**, who do not have **signs** or **symptoms**, is not recommended.

REPORTS REQUIRED:

Outbreak reports are required. However, if a food handler, child care staff or worker in a health care facility is a **case** or **suspect case** an immediate telephone report to the local health department is required.

SPECIAL FEATURES:

Infected individuals without signs or symptoms can spread this parasite by poor hygiene habits. This illness is often spread from child to child in diapered groups. Stress careful handwashing after toileting, after changing diapers, before food preparation and before eating.

See Handwashing, Infection Control Measures, and Parent Alert Letter.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Diseases and Conditions: <http://www.cdc.gov/giardia/>

SECTION II—HAND, FOOT AND MOUTH DISEASE

(COXSACKIE VIRUS INFECTION)

SIGNS AND SYMPTOMS:

Fever and a sore throat accompanied by small sores in the mouth. Small blister-like rash may be present on the hands and feet. Occasionally a rash may be present on the buttocks.

IMMEDIATE INTERVENTION:

Exclude while fever is present. See Special Features below.

INCUBATION PERIOD:

Usually 3–6 days.

CONTAGIOUS PERIOD:

Most contagious during the time when the fever and sore throat are present, but the virus (enterovirus) may be present in the stool for several weeks.

TRANSMISSION:

Contact with secretions from the nose, mouth, and throat. Also stool-to-mouth (fecal-oral) spread by way of unwashed hands, or foods contaminated by unwashed hands.

SCHOOL/CHILD CARE ATTENDANCE:

Exclude until fever-free for 24 hours without the use of fever-reducing medications and the individual feels well-enough to return. Consider exclusion for very young children with mouth sores and uncontrolled drooling.

REPORTS REQUIRED:

No reports are required.

SPECIAL FEATURES:

The Centers for Disease Control and Prevention makes no specific recommendation regarding the exclusion of children with Hand, Foot and Mouth Disease but offers that “children are often excluded from group settings during the first few days of the illness, which may reduce the spread of infection, but will not completely interrupt it.”

The American Academy of Pediatrics (AAP) in their book, Managing Infectious Diseases in Child Care and Schools, Third Edition, 2013, notes that “exclusion will not reduce disease transmission because some children may shed the virus without becoming recognizably ill, and other children who became ill may shed the virus for weeks in the stool.”

The editors of this Resource Guide have adopted the AAP’s least restrictive recommendations but support schools and early care and education programs in the development of written exclusion policies which best fit their setting.

Hand, Foot and Mouth Disease is seen most often in the summer and early fall. Care in handwashing, handling diapers and all items contaminated with stool and secretions of the nose, mouth and throat is essential.

Most enteroviral infections during pregnancy cause mild or no illness in the mother. There is no clear evidence that maternal enteroviral infection causes adverse outcomes of pregnancy.

See Handwashing, Rash Flow Chart, Features of Rash Illness, Infection Control Measures and Parent Alert Letter.

SECTION II—HAND, FOOT AND MOUTH DISEASE

(COXSACKIE VIRUS INFECTION)



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Hand, Foot and Mouth Disease (Coxsackie Virus Infection) information:

<http://www.cdc.gov/Features/HandFootMouthDisease/>

SECTION II—HEAD LICE

(PEDICULOSIS)

SIGNS AND SYMPTOMS:

Itching of the scalp. Lice and nits (eggs) found in hair, especially at the nape of the neck and behind the ears.

IMMEDIATE INTERVENTION:

Refer the child for treatment at the **end of the day** if close head-to-head contact and sharing of clothing, linens, pillows, hats, helmets, barrettes, etc.; can be avoided.

INCUBATION PERIOD:

From 6–14 days.

CONTAGIOUS PERIOD:

As long as live lice are present on the head or in the environment. Following treatment, nits found on the hair more than 1/4" away from the scalp are usually dead.

TRANSMISSION:

Direct head-to-head contact between individuals, or indirect spread through shared items such as combs, brushes, head phones, towels, hats, coats, and sleeping mats or cots. Upholstered furniture, car upholstery, rugs, carpets and items like stuffed animals can harbor head lice. Head lice can survive off the body for 1–2 days, allowing for **re-infestation**. Household pets are not a source of head lice.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Refer the child for treatment at the end of the day if close head-to-head contact and sharing of clothing, linens, pillows, hats, helmets, barrettes, etc.; can be avoided. The individual can return when the initial treatment has been completed. As many nits as possible should be removed with a fine-tooth comb.

Contacts: All family members, close **contacts** and classroom **contacts** should be checked and treated if **infestation** is found.

REPORTS REQUIRED:

No reports are required. If there is an unusual increase in the number of individuals infested (above 10% in a single group setting), notify the local health department for additional management steps.

SPECIAL FEATURES:

Many effective over-the-counter products are available without a prescription. Home remedies (like petroleum jelly, mayonnaise, and some herbal products) are most often ineffective and some (like kerosene) are dangerous. Pregnant women and the parents of children ages 0–2 should contact a health care provider for treatment recommendations. Where exclusion is not practical (shelters, crisis nurseries, overnight camps) procedures which include treatment, screening of contacts and environmental management must be carried out immediately and at the same time as treatment.

EDUCATE PARENTS ON TREATMENT STEPS.

- Shaving the head is unnecessary!
- Follow specific treatment directions found with the product used on the hair.
- Shampoo-type products in which the active ingredient is 0.3% pyrethrin are effective, but must be used again 7–10 days (day 9 being most effective) after the first treatment;

SECTION II—HEAD LICE

(PEDICULOSIS)

- A cream rinse product containing permethrin should be used again if live lice are seen. Recent recommendations suggest routine re-application at day 9 after the first application. Do not use nit-loosening agents, such as vinegar or commercial preparations after using a permethrin cream rinse;
- 0.5% ivermectin lotion (Sklice®), available by prescription, should be effective after a single application;
- New products spinosad (Natroba®) and topical benzyl alcohol (Ulesfia®) are also available by prescription;
- Lindane is no longer recommended as a first line treatment for head lice;
- Remove as many nits as practical focusing on those within ¼" from the scalp. Use a fine-tooth comb or pick nits from the hair with fingers or nit-removal tweezers. Discard or sanitize the comb, tweezers, and wash clothing and towels which were used immediately;
- Contact a health care provider if live lice are present after two treatments;
- Wash recently used clothing, bedding, towels, combs, and brushes with soap and hot water (at least 130° F) for 10 minutes or dry clean;
- Place items that cannot be cleaned (stuffed animals for example) in a sealed plastic bag for 14 days;
- Vacuum carpets, mattresses, upholstered furniture;
- Environmental pesticide sprays are not recommended for lice management in the home or group setting.
- Nit-free policies are not recommended for school and child care settings.

See Parent Alert Letter.

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Head Lice (Pediculosis) information: <http://www.cdc.gov/parasites/lice/head/>
http://www.cdc.gov/parasites/lice/head/gen_info/faqs.html
<http://www.cdc.gov/parasites/lice/head/schools.html>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding): <http://www.mothertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION II—HEPATITIS A



SIGNS AND SYMPTOMS:

In adults and older children: sudden onset with loss of appetite, **nausea**, vomiting, **listlessness**, **fever**, abdominal pain. Often followed by **jaundice**, or dark-colored urine (strong tea-colored or cola-colored).

Young children with hepatitis A disease often have no **symptoms**, or mild **symptoms**

IMMEDIATE INTERVENTION:

Refer to a health care provider for evaluation and diagnosis.

INCUBATION PERIOD:

From 15–50 days; average 25–30 days.

CONTAGIOUS PERIOD:

From 1–3 weeks. Most contagious up to 2 weeks before the onset of illness. No longer contagious 1 week after the onset of **jaundice**.

TRANSMISSION:

From stool-to-mouth (fecal-oral) spread by way of unwashed hands or foods contaminated by unwashed hands. Hands can become contaminated during toileting and diapering activities.

SCHOOL/CHILD CARE ATTENDANCE:

Because of increased opportunities for spread in the child care setting, management will differ from the school setting. See **Contacts**.

Cases: Exclude for 7 days after the illness began and the individual feels well enough to return.

Contacts: Contacts: Hepatitis A vaccine or **immune globulin** (called IG, ISG or GG) is often recommended for **household contacts**, and child care **contacts** as a preventive measure. Only rarely will hepatitis A vaccine or **immune globulin** be recommended as a preventive measure for possible contacts in the public school setting. This decision is based on case-by-case investigation by the local health department. To be effective, hepatitis A vaccine or **immune globulin** must be given to contacts within 2 weeks of the last exposure to the infected individual. Hepatitis A vaccine and **immune globulin** are safe for pregnant women. Hepatitis A vaccine is often administered at the same time as **immune globulin**.

REPORTS REQUIRED:

Immediate telephone reports of **cases** or **suspected cases** to the local health department are required. Reporting is vital if the infected individual is a food handler. Also, contact the local health department if 2 or more children have household contacts diagnosed with hepatitis A.

SPECIAL FEATURES:

Hepatitis A is a viral infection of the liver. This infection interferes with liver's ability to digest food and keep the blood healthy. Most people will recover completely from this infection and maintain lifelong immunity to Hepatitis A Virus.

Careful handwashing, monitoring of diapering practices and management of soiled diapers are important prevention steps.

Because Hepatitis A Virus may survive on objects in the environment for weeks, careful cleaning and sanitizing of diaper changing areas, bathrooms, and food service areas is important.

Routine immunization schedules include Hepatitis A vaccine.

See Handwashing, Immunization Schedules Infection Control Measures, and Parent Alert Letter.

SECTION II—HEPATITIS A



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Hepatitis A information: <http://www.cdc.gov/hepatitis/A/aFAQ.htm>
<http://www.cdc.gov/hepatitis/A/PDFs/HepAGeneralFactSheet.pdf>
<http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-hep-a.pdf>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding): <http://www.mohtertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

Diaper Changing Procedures: Caring for Our Children: National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, 3rd Edition: <http://cfoc.nrckids.org/StandardView/3.2.1.4>

SECTION II—HEPATITIS B

SIGNS AND SYMPTOMS:

Gradual onset of illness may include: loss of appetite, **nausea**, vomiting, abdominal pain, dark-colored urine (strong tea-colored or cola-colored), **jaundice**, **diarrhea**, itching of the skin, muscle and joint pain. Early symptoms vary with individuals. Young children may have mild or no **signs** and **symptoms**.

IMMEDIATE INTERVENTION:

Refer to a health care provider for evaluation, diagnosis and treatment.

INCUBATION PERIOD:

From 45–180 days, average 60–90 days.

CONTAGIOUS PERIOD:

When a hepatitis B surface antigen (HBsAg) blood test is positive. This blood test may be positive for the rest of an individual's life.

TRANSMISSION:

CASUAL CONTACT with a hepatitis B virus (HBV)-infected person presents no risk of catching the infection. HBV can be transmitted from person-to-person through:

- Sexual intercourse (anal, vaginal, or rarely oral), with an infected individual;
- Sharing HBV-contaminated intravenous needles and syringes used for street drugs, steroids or tattoos;
- Careless handling of items contaminated with infected blood or body fluids (bandages, tissues, paper towels, diapers, gloves, sanitary pads, hypodermic needles/syringes);
- Saliva of an HBV-infected individual who bites another when the bite breaks the skin (rarely);
- Rarely, transfusion of infected blood or blood products;
- From an infected mother to her baby in the womb, during birth, and possibly through breast feeding.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until the individual's signs and symptoms have disappeared and the person feels well enough to return. Also exclude if the individual has weeping sores which cannot be covered or has a bleeding problem. A child with hepatitis B infection who exhibits biting or scratching behaviors may need to be excluded from the group setting while the aggressive behavior is addressed.

Contacts: No restrictions. For significant exposure, a health care provider may recommend immediate **immunization** with Hepatitis B **immune globulin** (HBIG). Hepatitis B vaccine may also be indicated.

REPORTS REQUIRED:

Health care providers are required to report **cases** and **suspect cases**.

SPECIAL FEATURES:

Hepatitis B is an infection of the liver. This infection interferes with liver's ability to digest food and keep the blood healthy. Hepatitis B can result in mild illness, chronic (long-lasting) infection, permanent liver damage, or death due to liver failure. While some people completely recover from this infection, hepatitis B can result in mild illness, lifelong infection, permanent liver damage, liver failure, liver cancer and death.

Hepatitis B vaccine is included in routine **immunization** schedules for all children. All required doses must be received for the individual to be protected.

SECTION II—HEPATITIS B

Babies born to mothers infected with HBV have a 90% chance of being infected with HBV for the rest of their lives, which can lead to liver damage, cirrhosis, and liver cancer. Babies born to a mother infected with HBV must immediately receive hepatitis B vaccine and hepatitis B immune globulin. Hepatitis B vaccine and **HBIG** need to be given within 12 hours of birth.

Individuals who are sexually active (especially with more than 1 partner), use needles to shoot drugs, are exposed to blood or **body fluids** at work, or live in a household with someone who is infected with HBV, should talk with their health care provider about receiving Hepatitis B vaccine and steps to reduce the risk of acquiring hepatitis B.

Because HBV may survive on objects in the environment for 7 days or longer, careful cleaning and disinfecting of blood spills or items contaminated with blood is important.

Schools and child care centers should have procedures in place to address blood and body fluid contact and clean-up.

See Handwashing, Immunization Schedule, and Infection Control Measures.

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Hepatitis B information: <http://www.cdc.gov/hepatitis/B/bFAQ.htm>
<http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-hep-b.pdf>

Diaper Changing Procedures: Caring for Our Children: National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, 3rd Edition: <http://cfoc.nrckids.org/StandardView/3.2.1.4>

SECTION II—HERPES SIMPLEX

(COLD SORES, FEVER BLISTERS, GENITAL HERPES)

SIGNS AND SYMPTOMS:

Fever Blisters: Typically, clusters of tiny, fluid-filled blisters on a reddened base of skin around the lips, in the mouth or on the face. These blisters crust and heal within a few days. Also called “cold sores”. **Genital Herpes:** Clusters of very small (pencil-point size) fluid-filled blisters on a reddened base of skin in the genital area.

IMMEDIATE INTERVENTION:

Fever Blisters: Isolate and exclude only if child has fever or blisters in the mouth or on the lip and cannot control drooling. For others, cover sores with a bandage if possible. **Genital Herpes:** Isolate, exclude and refer to the health care provider for diagnosis and treatment.

INCUBATION PERIOD:

Within 2 weeks

CONTAGIOUS PERIOD:

From the onset of the blisters until they are scabbed over and fall off and the skin is normal. Generally from 1 to 3 weeks. However, herpes may be contagious even when symptoms are not present.

TRANSMISSION:

Fever Blisters: Direct contact with the virus in saliva, sores or drool.

Genital Herpes: Through intimate sexual contact. Herpes infections may be transmitted to an infant, from the infected mother, in the birth canal during delivery.

SCHOOL/CHILD CARE ATTENDANCE:

Because of the increased opportunities for spread in the child care setting, management will differ from the school age setting.

Cases (Child Care):

Fever Blisters: Exclude only if child has fever or blisters in the mouth or on the lip and cannot control drooling. For others, cover sores with a bandage if possible.

Genital Herpes: Exclude until fever-free for 24 hours without the use of fever-reducing medications and genital sores are scabbed over.

Cases (School): Exclude until fever-free for 24 hours without the use of fever-reducing medications.

Contacts: No Restrictions

REPORTS REQUIRED:

Case reports for genital herpes are required from health care providers. For others settings, notify the local health department for management steps if there is an outbreak of fever blisters or genital herpes.

SPECIAL FEATURES:

Both fever blisters and genital herpes are caused by infections with specific types of the Herpes Simplex Virus (HSV). Herpes Simplex type I generally causes infections around the mouth and Herpes Simplex type II generally causes infections in the genital region of the body. However, either type may infect the mouth or genitals.

Worldwide, 50–90% of adults have been infected with HSV type I before the age of five. Infection with HSV type II generally occurs with sexual activity and is rare before adolescence.

SECTION II—HERPES SIMPLEX

(COLD SORES, FEVER BLISTERS, GENITAL HERPES)

In the case of genital herpes in children, the possibility of sexual abuse cannot be ignored. Make reports to the **Arizona Child Abuse Hotline at 1-888-SOS-CHILD** (1-888-767-2445) or law enforcement.

Good personal and environmental hygiene is important when individuals have fever blisters or genital herpes. Sores should be carefully washed with soap and rinsed with water. Ointments and creams should not be applied unless prescribed by the health care provider. Individuals should be discouraged from picking at sores because the virus is concentrated in the fluid of the blisters. Eyes can become infected; remind individuals to keep their hands away from their eyes. Do not share items such as face cloths, handkerchiefs, bathing suits, undergarments or towels, which may have come into contact with the virus, before laundering.

Health education regarding sexually transmitted diseases (STD's) such as herpes, including signs and symptoms and how they are spread, should be included in age appropriate human development curriculum.

Treatment of STD's is available through local health department clinics, specialized community clinics and private health care providers. Arizona State laws allow minors to obtain treatment of STD's without parental consent.

Herpes Simplex may cause life-threatening infections in individuals who are immuno-compromised in any way. Dispose of tissues and treatment cotton, swabs, gauze, etc. after one use. Use face cloths, napkins, eating utensils, undergarments, etc. with one individual before washing, laundering or sanitizing thoroughly. Do not share mouthed items or clothing while symptoms are present

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

HealthyChildren.org:

<http://www.healthychildren.org/English/health-issues/conditions/skin/pages/Herpes-Simplex-Virus-Cold-Sores.aspx>

CDC: <http://www.cdc.gov/std/Herpes/STDFact-Herpes.htm>

SECTION II—HUMAN IMMUNODEFICIENCY VIRUS

(HIV/AIDS)

SIGNS AND SYMPTOMS:

HIV Positive: Evidence of HIV infection in specific blood tests. Most individuals do not develop symptoms of illness for 1–12 years or even longer after infection.

Symptomatic HIV disease: Swelling of lymph nodes, loss of appetite, chronic **diarrhea**, weight loss, **fever**, fatigue, and night sweats. These signs and symptoms are not sufficient by themselves to make a diagnosis of AIDS.

AIDS: The last stage of HIV infection when an individual becomes very sick. Children with AIDS have difficulty fighting off some common infections and may have unusual infections. In infants and children less than 13 years old, **signs** may include: failure to grow and develop normally, and recurrent severe bacterial infections.

IMMEDIATE INTERVENTION:

Refer to a health care provider for diagnosis.

INCUBATION PERIOD:

Variable. Infants infected in the womb or during birth may develop signs and symptoms as early as 12 to 18 months of age. Older children and adults may be symptom-free for years.

The period from infection with the virus, until results from blood tests are positive for HIV, varies from 2 weeks to 6 months. Newborns of HIV-infected mothers will always carry maternal antibodies (test positive) for up to 15 months, even though most infants are not themselves infected.

CONTAGIOUS PERIOD:

Begins early after HIV infection and continues throughout life. Infected individuals are infectious although **signs** and **symptoms** may not be present.

TRANSMISSION:

HIV is not spread through the kinds of daily activities which occur in child care and school. **Casual contact** with an HIV-infected person carries no risk of catching the infection, and the infection is NOT spread easily through child care or school activities in the absence of visible blood. HIV can be transmitted from person-to-person through:

- Sexual intercourse (anal, vaginal or more uncommonly oral), with an infected individual;
- Sharing HIV-contaminated intravenous needles and syringes used for street drugs, steroids or tattoos;
- Through transfusion of infected blood or blood products received before 1985;
- An infected mother to her baby in the womb, during birth, and through breast feeding.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: No restrictions. The benefits of education in an unrestricted setting outweigh the very small risk of **transmission** of HIV in the school or child care setting. The local health department can assist the school or child care administration and parents in decisions regarding the setting.

Communicable diseases pose a risk to the HIV-infected child. This child's family should be alerted to the potential risks of infectious diseases in the group setting. If cases of infectious disease such as measles chickenpox, or whooping cough are identified in the group setting, temporary removal of the HIV-infected child may be recommended.

Contacts: No restrictions.

REPORTS REQUIRED:

No reports required for schools or child care programs.

SECTION II—HUMAN IMMUNODEFICIENCY VIRUS

(HIV/AIDS)

SPECIAL FEATURES:

Sources for **transmission**: blood, semen, vaginal fluid and breast milk.

HIV-infected adults with no symptoms of illness may care for children in facilities provided they do not have open skin sores or other conditions that would allow contact of their blood or body fluid with children or other adults.

Education should address the fear and misunderstanding about HIV as well as the disease process, routes of **transmission** (not casually transmitted), and the use of Infection Control Measures.

Schools and child care centers should have procedures in place to provide guidance to all staff responsible for children to prevent the spread of HIV.

Such procedures should include precautions to be taken during the clean-up of blood or body fluid spills. Because HIV infection may be unidentified, the same infection control procedures (universal precautions) should be applied to all individuals in the group setting.

See Handwashing, and Infection Control Measures.

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Human Immunodeficiency Virus (HIV/AIDS) information: <http://www.cdc.gov/hiv/topics/basic/index.htm>

HealthyChildren.org:

<http://www.healthychildren.org/English/health-issues/conditions/sexually-transmitted/Pages/HIV-and-AIDS.aspx>

SECTION II—IMPETIGO

O

SIGNS AND SYMPTOMS:

Skin sores which may have a honey-colored, gummy, crusty or blister-like appearance. Most often seen around the nose and mouth, or on the buttocks of a diapered child. Often itchy.

IMMEDIATE INTERVENTION:

Cover with bandage and refer to a health care provider for diagnosis and treatment.

INCUBATION PERIOD:

Commonly 7–10 days.

CONTAGIOUS PERIOD:

As long as untreated sores are present or until sores are treated with oral antibiotics for 24 hours.

TRANSMISSION:

Direct contact with the sores, or contaminated hands. Also items that have come into contact with the discharge from the sores such as face cloths, tissues, or diapers.

SCHOOL/CHILD CARE ATTENDANCE:

Because of the increased opportunities for spread in the child care setting, management will differ from the school setting.

Cases Child Care: Exclude individuals if the sores cannot be completely covered with a bandage and refer for **antibiotic** treatment. Can return 24 hours after starting oral **antibiotics** or 48 hours if only **antibiotic** ointment is prescribed by the health care provider.

School: No attendance restrictions for infected individuals, but the individual should not participate in activities involving direct body contact. Weeping sores should be covered.

Food handlers: Exclude from food handling while sores are present. Refer to a health care provider for diagnosis and treatment.

Contacts: No restrictions.

REPORTS REQUIRED:

If there is an unusual increase in the number of individuals infected (or 3 or more cases, not from the same household, within the same week) notify the local health department for additional management steps.

SPECIAL FEATURES:

Very contagious. Should be treated with **antibiotics**. Stress careful handwashing, and sanitation procedures. All paper towels, tissues, bandages and gloves must be disposed of immediately after one use. Proper laundering of contaminated clothing, and bed and bath linens must be stressed. Both staphylococcus and streptococcus bacteria can cause impetigo.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Impetigo information: http://www.cdc.gov/ncidod/dbmd/diseaseinfo/groupastreptococcal_g.htm

WebMD: <http://www.webmd.com/skin-problems-and-treatments/tc/impetigo-overview>

SECTION II—INFLUENZA

(FLU)

SIGNS AND SYMPTOMS:

Sudden onset of **fever** (100.4 or higher), chills, headache, muscle ache, sore throat, runny nose and cough. Occasionally vomiting or diarrhea can occur. Usual recovery in 2–14 days without treatment although some children can develop complications that can be severe.

IMMEDIATE INTERVENTION:

Exclude.

INCUBATION PERIOD:

From 24–72 hours.

CONTAGIOUS PERIOD:

1 day before until 7 days after **signs** and **symptoms** begin.

TRANSMISSION:

Contact with **secretions** from the nose, mouth and throat of an infected person. The **secretions** may be on surfaces or in infected droplets in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until symptoms subside and the individual is **fever-free** for 24 hours without the use of fever-reducing medications without the use of fever-reducing medicines such as acetaminophen, or ibuprofen. Aspirin should not be used to reduce fever in children under the age of 18.

Contacts: No restrictions.

REPORTS REQUIRED:

None. If there is an unusual absentee rate (above 10% of individuals in a single group setting) with upper respiratory infections, notify the local health department for additional management steps.

SPECIAL FEATURES:

Influenza is caused by a virus.

Influenza immunization is recommended for all individuals ages 6 months and older. Since there is no influenza vaccine available for infants under 6 months of age, infant caregivers should consider receiving vaccine themselves to help protect the infants they care for. Adults and children with chronic health problems and adults who care for children with chronic health problems should consider influenza immunization each year. Pregnant women should receive influenza immunization. Changes in the immune system and heart and lung functions during pregnancy increase serious illness from influenza. Pregnant women who get influenza are at higher risk of hospitalization, and even death, than non-pregnant women. Influenza immunizations for all children ages 6 months and older and adults can help to keep everyone healthier.

Complications can include bacterial pneumonia and **Reye's Syndrome** in children. The use of aspirin products for the management of influenza symptoms has been associated with **Reye's syndrome**. Aspirin products are not recommended for fever reduction in children under the age of 18.

See Handwashing, Infection Control Measures, and Parent Alert Letter.

SECTION II—INFLUENZA

(FLU)



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Influenza (Flu) information: <http://www.cdc.gov/flu/keyfacts.htm>
<http://www.cdc.gov/flu/about/qa/flu vaccine.htm>
<http://www.cdc.gov/flu/school/index.htm>
<http://www.cdc.gov/flu/protect/infantcare.htm>
<http://www.cdc.gov/flu/protect/children.htm>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding): <http://www.mothersandbaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION II—MEASLES



(RUBEOLA)

SIGNS AND SYMPTOMS:

Fever, red, watery eyes, sore throat, runny nose, and cough. Small white spots may be seen in the mouth. These signs and symptoms are followed by a blotchy red rash which begins on the head and face and spreads to the rest of the body.

IMMEDIATE INTERVENTION:

Isolate, exclude and refer to a health care provider for diagnosis. Call the local health department immediately to report all rashes accompanied by **fever**.

INCUBATION PERIOD:

About 10 days, varying from 7–18 days; about 14 days until rash appears.

CONTAGIOUS PERIOD:

From 4 days before the rash appears to 4 days after the rash appears.

TRANSMISSION:

Measles is highly contagious and can be spread by contact with **secretions** from the nose, mouth and throat of an infected individual. These **secretions** may be on surfaces or in infected droplets in the air. Droplets infected with measles virus can remain in the air for many hours.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude from the time of onset of illness through the 4th day after rash appears, and until the individual is **fever-free for 24 hours without the use of fever-reducing medications**.

Contacts: Any individual who has not received measles vaccine or who cannot prove immunity by immunization or blood test must not be permitted to attend school or child care for the duration of the period of the outbreak as determined by the local health department.

An outbreak is defined as one (1) case of measles.

REPORTS REQUIRED:

Immediate telephone report to the local health department is required. **Case** and **suspect case** reports are also required.

SPECIAL FEATURES:

Parents should alert the health care provider of any rash-illness before transporting the child to a health care facility.

All **suspect cases** or diagnosed **cases** of measles are investigated by the local health department to reduce exposure risks to others.

Measles is prevented by age-appropriate **immunizations**. During community **outbreaks**, local health department officials may recommend early immunization for infants, which may provide incomplete immunity. For this reason children must receive two measles vaccinations after 12 months of age.

Review histories of **immunization** to identify individuals who are **susceptible** to measles.

The following persons should receive measles vaccine within 72 hours of exposure to measles. This reduces the chances of becoming ill and allows re-entry into the school or child care setting:

- Any individual who does not have a record (month, day, and year) of receiving age-appropriate doses of measles vaccine;

SECTION II—MEASLES



(RUBEOLA)

- Individuals with age-appropriate measles immunization who are determined by the local health department to need additional protection against measles; **or**
- Those who do not have a positive blood test (titer) demonstrating immunity to measles.

Contracting measles during pregnancy may be associated with a higher risk of prematurity and miscarriage. As measles vaccine is not routinely given during pregnancy, a woman who is pregnant and exposed to measles should consult her health care provider. Immune globulin may be recommended.

Rubeola (measles) is also known as: hard measles, red measles and the 10-day measles.

See Handwashing, Rash Flow Chart, Features of Rash Illness, Infection Control Measures, Immunization Schedule, and Parent Alert Letter.

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Measles (Rubeola) information: <http://www.cdc.gov/measles/about/index.html>
<http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mmr.pdf>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding): <http://www.mothertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION II—MENINGITIS (HIB)



(HAEMOPHILUS INFLUENZAE TYPE B)

SIGNS AND SYMPTOMS:

Onset of **signs** and **symptoms** may be gradual, but usually are sudden. High fever, vomiting, and **listlessness** progressing to coma is common. Occasionally there is mild **fever** for several days before the onset of other **symptoms** such as stiff neck and/or stiff back accompanied by pain. A bulging (swollen) fontanel may be present in infants.

IMMEDIATE INTERVENTION:

Isolate. **Immediate medical attention** is required.

INCUBATION PERIOD:

Unknown. Probably short, 2–4 days.

CONTAGIOUS PERIOD:

As long as the bacteria are present in nose, throat and mouth secretions.

TRANSMISSION:

Contact with infected **secretions** from the nose, mouth, throat and ears. These **secretions** may be on surfaces or in infected droplets in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until the individual is **symptom**-free and the health care provider and local health department indicate the child may return (usually after taking antibiotics for 24 hours).

Contacts: **Rifampin** is often given to household and child care **contacts** identified by the local health department as needing preventive antibiotics.

REPORTS REQUIRED:

Immediate telephone report of **cases** and **suspect cases** to the local health department.

SPECIAL FEATURES:

Protective **immunizations** are a part of the routine immunization schedule for children ages 2 months–60 months. Due to required immunizations, meningitis caused by Hib has become uncommon in healthy children.

Dispose of tissues immediately after one use; use face cloths one time and on only one child before laundering.

Serious complications such as hearing loss, mental retardation and death may result from delays in seeking medical attention. Haemophilus influenzae type b bacteria can also cause sudden and severe throat infections (**epiglottitis**), pneumonia, ear, skin and joint infections.

Meningitis may also be caused by other bacteria, see Meningitis (Meningococcal) and by a virus, see Meningitis (Viral).

See Handwashing, Infection Control Measures, Immunization Schedule, and Parent Alert Letter.

SECTION II—MENINGITIS (HIB)



(HAEMOPHILUS INFLUENZAE TYPE B)



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Meningitis (Hib) (Haemophilus influenzae type b) information:

<http://www.cdc.gov/Features/HibDisease/>

<http://www.cdc.gov/vaccines/vpd-vac/hib/in-short-adult.htm>

<http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-hib.pdf>

<http://www.cdc.gov/meningococcal/about/index.htm>

SECTION II—MENINGITIS (MENINGOCOCCAL)



SIGNS AND SYMPTOMS:

Sudden onset of fever, intense headache, nausea and vomiting, stiff neck.

Sometimes accompanied by a rash of flat, red or purple spots. These spots can become very large.

IMMEDIATE INTERVENTION:

Isolate, exclude and refer to a health care provider. Immediate medical attention is required.

INCUBATION PERIOD:

Varies from 2–10 days, commonly 3–4 days.

CONTAGIOUS PERIOD:

As long as the bacteria are present in nose, mouth and throat secretions.

TRANSMISSION:

Contact with secretions from the nose, mouth and throat of an infected person. The secretions may be on surfaces, tissues, mouthed-toys, or in infected droplets in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until the individual is symptom-free, receives **antibiotic** treatment, and the local health department or health care provider indicates the individual may return.

Contacts: No restrictions. Close observation for early signs of illness.

Rifampin, ciprofloxacin or ceftriaxone may be given to reduce the spread of disease to household, child care, and occasionally close school contacts.

REPORTS REQUIRED:

Immediate telephone report of **case** and **suspect case**, are required.

SPECIAL FEATURES:

Most cases occur in older children, teens and adults.

Dispose of tissues immediately after one use; use face cloths one time and on only one individual before laundering.

Serious complications such as hearing loss, mental retardation and death may result from delays in seeking medical attention. Specific meningococcal vaccines are used in specific age groups. Meningococcal conjugate vaccine (MCV4) is recommended for children at age 11–12 years as well as for unvaccinated adolescents at high school entry (age 15 years). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated with MCV4 or meningococcal polysaccharide vaccine (MPSV4). Children ages 9 months–10 years old with certain high-risk conditions should receive MCV4. Vaccination may also be recommended for other children in certain high-risk groups. In addition, healthy children who travel to areas where meningococcal meningitis is widespread should also receive MCV4.

Meningitis may also be caused by other bacteria such as Haemophilus influenza type b or by a virus. See Meningitis (Hib) and Meningitis (Viral).

See Handwashing, Rash Flow Chart, Infection Control Measures and Parent Alert Letter.

SECTION II—MENINGITIS (MENINGOCOCCAL)



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Meningitis (Meningococcal) Information: <http://www.cdc.gov/Features/Meningococcal/>
<http://www.cdc.gov/meningitis/about/index.html>
<http://www.cdc.gov/vaccines/vpd-vac/mening/who-vaccinate-hcp.htm>
<http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding): <http://www.mothertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION II—MENINGITIS (VIRAL)

SIGNS AND SYMPTOMS:

Sudden onset of **fever**, intense headache, **nausea** and vomiting, stiff neck. Sometimes irritability and sensitivity to bright light.

IMMEDIATE INTERVENTION:

Isolate, exclude and refer to a health care provider. **Immediate medical attention** is required.

INCUBATION PERIOD:

Varies from 2–35 days, commonly within 7 days of exposures. Viral meningitis can be caused by a number of different viruses, each with a distinct **incubation period**.

CONTAGIOUS PERIOD:

As long as the virus is present in nose, mouth or throat **secretions**, or in the stool. This may be weeks. However, not all viral meningitis is contagious.

TRANSMISSION:

Depends on the type of virus but typically from stool-to-mouth (fecal-oral) spread by way of unwashed hands or foods contaminated by unwashed hands. Also, contact with the stool or **secretions** from the nose, mouth and throat of an infected person. The **secretions** may be on surfaces, tissues, mouthed-toys, etc.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until the individual is **symptom**-free or is cleared to attend by the health care provider.

Contacts: No restrictions.

REPORTS REQUIRED:

No reports are required. If 2 or more individuals are diagnosed with viral meningitis, contact the local health department for recommendations.

SPECIAL FEATURES:

Viral meningitis is an infection of the thin covering of the brain and spinal cord (meninges). It is caused by many kinds of viruses, with the most common cause being intestinal viruses (enteroviruses). Most people are exposed to these viruses at some time, **but very few will develop meningitis**.

Most cases occur in children, teens and young adults. Cases increase in the summer months. Almost all cases occur as a single isolated event. Outbreaks are rare.

Serious complications such as hearing loss, mental retardation and death may be a result of viral meningitis but are rare.

Careful handwashing, monitoring of diapering practices and management of soiled diapers are important prevention steps.

There are no specific medicines or antibiotics used to treat viral meningitis.

Meningitis may also be caused by bacteria. See Meningitis (Hib) and Meningitis (Meningococcal).

See Handwashing, Rash Flow Chart, Infection Control Measures and Parent Alert

SECTION II—MENINGITIS (VIRAL)

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Meningitis (Viral) information: <http://www.cdc.gov/meningitis/index.html>
<http://www.cdc.gov/meningitis/about/faq.html#causes>

SECTION II—METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS

(MRSA)

SIGNS AND SYMPTOMS:

A sore, bump, pimple or boil which can be red, swollen, painful, or have pus or other drainage. May look like a spider bite or infected cut or scrape. May also cause internal infections.

IMMEDIATE INTERVENTION:

Do not squeeze or “pop” boils or pimples. Cover with a clean, dry bandage and refer to a health care provider for diagnosis and treatment.

INCUBATION PERIOD:

Variable. Typically 4–10 days.

CONTAGIOUS PERIOD:

As long as sores are draining.

TRANSMISSION:

Direct contact with sores or contaminated hands; also items that have come into contact with discharge from sores such as bandages, face cloths, tissues or diapers.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude if sores cannot be covered and the bandage kept dry and intact.

Contacts: No restrictions.

REPORTS REQUIRED:

If more than one active infection in a classroom, contact the local health department for recommendations.

SPECIAL FEATURES:

A MRSA (pronounced mer-sa) infection, unlike a common *Staphylococcus aureus* infection, does not respond to treatment with the most common antibiotics. Consequently, the treatment with alternative antibiotics is often longer, more expensive, and more complicated, with frequent recurrence of infections. MRSA is not more contagious or more “deadly” than other staphylococcal infections. All bacterial infections can be serious. Treat any draining wound as potentially infectious. Do not permit others to come into contact with an infected child’s sore or wound or drainage from the sore or wound. Do not permit children to use bedding or mats that are used by children with draining wounds. Remind parents to communicate with caregivers regarding the health care provider’s diagnosis and treatment of any sores or wounds children have. The health care provider may determine that the child does not need an antibiotic, therefore the school or child care program should not require antibiotic treatment for readmission. If an antibiotic is prescribed, the child must take all medication even after the infection seems to have healed. Assure that the medications are administered in the correct dose and at the appropriate time.

About 10% of individuals in the general population may be colonized with MRSA but not have sores or other signs and symptoms. That means the bacteria are present on the individual’s skin or in the nose but are doing no harm to the individual.

See Handwashing, Infection Control Measures, and Parent Alert Letter.

SECTION II—METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS

(MRSA)



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Methicillin Resistant Staphylococcus Aureus (MRSA) information:

<http://www.cdc.gov/mrsa/>

http://www.cdc.gov/mrsa/mrsa_initiative/skin_infection/PDF/GP/MRSA_EarlyEd_FactSht.pdf

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding) <http://www.mothertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION II—MONONUCLEOSIS

(INFECTIOUS)

SIGNS AND SYMPTOMS:

Fever, sore throat, **listlessness**, swollen lymph nodes in the neck commonly occur. Skin rash may appear on neck and shoulders or **jaundice** may develop.

IMMEDIATE INTERVENTION:

Refer to a health care provider for diagnosis.

INCUBATION PERIOD:

Approximately 30–50 days.

CONTAGIOUS PERIOD:

Prolonged. Possibly up to a year or more.

TRANSMISSION:

Contact with **secretions** from the nose, mouth and throat of an infected person. Most commonly, saliva (spit or drool).

SCHOOL/CHILD CARE ATTENDANCE:

Because of the increased opportunities for spread in the child care setting, management will differ from the school setting.

Cases: Exclude until fever-free for 24 hours without the use of fever-reducing medications and the individual feels well-enough to return.

Contacts: No restrictions.

REPORTS REQUIRED:

None.

SPECIAL FEATURES:

This is a viral infection caused by the Epstein-Barr virus. This infection occurs most often in teens and young adults.

Symptoms may last for 2 weeks or longer.

Treatment may include rest with symptomatic treatment for discomfort and **fever**-reduction. Acetaminophen or other non-aspirin products may be prescribed for **fever**-reduction and the relief of aches and pains. Special attention to sanitation of mouthed toys is required. Utensils, drinking glasses and toothbrushes should not be shared.

Also known as “Kissing Disease”.

See Handwashing and Infection Control Measures.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Mononucleosis (Infectious) Information: <http://www.cdc.gov/ncidod/diseases/ebv.htm>

WebMD: <http://www.webmd.com/a-to-z-guides/infectious-mononucleosis-topic-overview>

SECTION II—MUMPS



(PAROTITIS)

SIGNS AND SYMPTOMS:

Pain and swelling of one or more of the salivary glands, located between the ear and the jaw. **Fever**, muscle aches, abdominal pain and listlessness may occur.

IMMEDIATE INTERVENTION:

Exclude and refer to a health care provider.

INCUBATION PERIOD:

Usually from 16–18 days, but cases may occur from 12–25 days after exposure.

CONTAGIOUS PERIOD:

Up to 3 days before swelling to 5 days after swelling appears.

TRANSMISSION:

Contact with the **secretions** of the nose, mouth and throat of an infected individual. The **secretions** may be on surfaces or in infected droplets in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until swelling subsides and child is **fever-free for 24 hours without the use of fever-reducing medications**, or for 5 days after the onset of swelling.

Contacts: In an outbreak, any individual who has not received mumps vaccine (MMR) may be excluded from attendance at school or child care for the duration of the outbreak as determined by the local health department.

REPORTS REQUIRED:

Immediate telephone reports to the local health department of cases and suspect cases are required.

SPECIAL FEATURES:

Mumps is caused by a virus. Mumps can be prevented by age-appropriate **immunization**. However, mumps can occur in individuals who have been immunized. **Outbreaks** are sometimes seen on high school and college campuses. Complications of the disease can include painful inflammation of the testes and ovaries, hearing loss, and inflammation of the joints.

See Handwashing, Infection Control Measures, Immunization Schedule, and Parent Alert Letter.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Mumps (Parotitis) information: <http://www.cdc.gov/mumps/index.html>
<http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mmr.pdf>
<http://www.immunize.org/catg.d/p4211.pdf>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding) <http://www.mothertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION II—NOROVIRUS

O

SIGNS AND SYMPTOMS:

Diarrhea, vomiting, and stomach pain. Sometimes low-grade fever and body aches.

IMMEDIATE INTERVENTION:

Isolate and exclude.

INCUBATION PERIOD:

12–48 hours

CONTAGIOUS PERIOD:

From the onset of illness to at least 3 days after recovery (and perhaps for as long as 4 weeks). Most contagious from the start of symptoms to 3 days after infection.

TRANSMISSION:

Direct contact with the virus by touching surfaces or objects that are contaminated with norovirus (doorknobs, keyboards, toys, etc.) or having contact with the stool or vomit of an infected person. Sometimes through eating food or drinking liquids that are contaminated with the virus.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until three days after recovery.

Contacts: No restrictions.

REPORTS REQUIRED:

Report increases of diarrhea and vomiting to the local health department.

SPECIAL FEATURES:

Norovirus is a common cause of community outbreaks of vomiting and diarrheal disease. Often called the “stomach flu” it is not related to influenza. Although symptoms might be severe, they typically resolve without treatment after 1–3 days in otherwise healthy persons. However, illness lasting 4–6 days can occur, particularly among young children and elderly persons. Dehydration can occur from frequent vomiting and diarrhea and may require medical assistance.

Careful handwashing with soap and water, especially after assisting an ill child, using the toilet and changing diapers and always before eating or preparing food is important. Alcohol-based hand sanitizers (containing at least 62% ethanol) may be a helpful addition to hand washing for adults and older children, but after handwashing with soap and water. Hand sanitizers are not as effective as handwashing in preventing infectious diarrhea.

People who have **signs** and **symptoms** of norovirus infection should not prepare food for others while they have symptoms and for 3 days after they recover from their illness.

Norovirus is not killed by many commonly used cleaning and disinfecting products. To clean up vomit or diarrhea, put on disposable waterproof gloves (single-use non-porous gloves) and immediately clean with soap and water. Then disinfect soiled surfaces with a bleach disinfectant. Check the label to see if the bleach product has an EPA registration number and follow the manufacturer’s safety and use instructions including the contact time required before wiping dry with a paper towel. If using other disinfectant products approved for norovirus mix and use according to the manufacturer’s instructions.

Place soiled bedding or clothing in a plastic bag before taking them to the laundry or sending them home. Do not place them in the child’s cubby or in a food preparation or food service area.

See Handwashing, Infection Control Measures.

SECTION II—NOROVIRUS

O

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Norovirus information: <http://www.cdc.gov/ncidod/dvrd/revb/gastro/norovirus.htm>

List of Approved Disinfectant Products for Norovirus: http://www.epa.gov/oppad001/list_g_norovirus.pdf

Selecting an Appropriate Sanitizer or Disinfectant from Caring for our Children: National health and safety performance standards; Guidelines for early care and education programs. 3rd edition.
<http://cfoc.nrckids.org/Bleach/Bleach.cfm>

SECTION II—PINWORMS

(ENTEROBIASIS)

SIGNS AND SYMPTOMS:

Signs and **symptoms** may be absent. Itching around the rectum (anus) at night

Very small (about the length of a staple), white, thread-like worms may be seen in stool, on under-clothing and/or on the genital region about an hour after the child has fallen asleep. Irritation may result from scratching the rectum and/or genital regions. The child may be irritable and sleep may be disturbed.

IMMEDIATE INTERVENTION:

If **signs** and **symptoms** are present, refer to a health care provider for management which may include medication.

INCUBATION PERIOD:

1–2 months or longer from the time an individual swallows a pinworm egg to the time an adult worm is found at the rectum.

CONTAGIOUS PERIOD:

As long as female worms are laying eggs around the rectum. Pinworm eggs can survive 2–3 weeks on carpets, linens and other contaminated objects/surfaces.

TRANSMISSION:

Swallowing of pinworm eggs. Eggs from the rectum are carried to the mouth on contaminated hands or articles.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: No restrictions.

Contacts: No restrictions.

REPORTS REQUIRED:

None required.

SPECIAL FEATURES:

Health education tips for parents and children:

- Pinworms may sometimes be seen by shining a flashlight on the anal area of a child who has been asleep for a short time (an hour or so). They appear as white threads, about 1½" long.
- Emphasize careful handwashing after using the bathroom, diapering a child and before eating.
- Discourage scratching of the rectum and genitals. Keep fingernails short and clean. Discourage nail biting and sucking of fingers.
- Pets are not a source of human pinworms.
- Recommend daily laundering and change of underwear, clothing and bed linen during the course of treatment. Daily morning showers (better than baths) recommended.
- Treatment of all household members at the same time may be advised. Recurrence is common.

See Handwashing, and Infection Control Measures.

SECTION II—PINWORMS

(ENTEROBIASIS)



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Pinworms (Enterobiasis) Information: <http://www.cdc.gov/parasites/pinworm/>
http://www.cdc.gov/parasites/pinworm/gen_info/faqs.html

SECTION II—RESPIRATORY SYNCYTIAL VIRUS

(RSV)

SIGNS AND SYMPTOMS:

During the early stages, mild, cold-like **signs** and **symptoms**, usually with fever over 102° for more than 1 day.

Coughing is the most frequent sign.

Cough, nasal congestion, and rapid breathing increase and may interfere with sleeping and eating. A sore throat may be present. An ear infection may also be present. **Signs** and **symptoms** may last for 1 to 2 weeks.

IMMEDIATE INTERVENTION:

Refer to a health care provider for diagnosis and treatment.

INCUBATION PERIOD:

Ranges from 2–8 days; commonly 4–6 days.

CONTAGIOUS PERIOD:

3–8 days is most common, however infants may continue shedding this virus for as long as 3–4 weeks.

TRANSMISSION:

Contact with **secretions** from the nose, mouth and throat of an infected person. The **secretions** may be on surfaces or in infected droplets in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until symptoms subside and the individual is fever-free for 24 hours without the use of fever-reducing medications.

Contacts: No restrictions.

REPORTS REQUIRED:

None. If there is an unusual absentee rate (above 10% of individuals in a single group setting) with upper respiratory infections, notify the local health department for additional management steps.

SPECIAL FEATURES:

RSV usually occurs in yearly outbreaks during winter and early spring.

Spread among **household** and child care **contacts**, including adults, is common.

Initial infection occurs most commonly during the first year of life. The majority of RSV infections are not serious; however, infants and young children may develop life-threatening illness requiring hospitalization for anti-viral treatment.

Other medical conditions such as asthma and chronic allergies may contribute to an individual's susceptibility to RSV and other respiratory infections.

A single infection with RSV generally does not make an individual immune to future RSV infections.

RSV infection is not easily distinguishable from other viral infections that cause respiratory **signs** and **symptoms**.

Secretions of the mouth, nose and throat can spread RSV. Cover coughs and sneezes with tissues and throw them away immediately. Follow immediately with hand washing. If no tissue is available cough or sneeze into the shoulder or upper arm. Avoid sharing eating utensils and cups. Prevent bottle and pacifier-sharing. Sanitize items and surfaces which are frequently used or touched often throughout the day.

SECTION II—RESPIRATORY SYNCYTIAL VIRUS

(RSV)

A drug called palivizumab is available to prevent severe RSV illness in infants and children who are at high risk for the disease. While the drug can help prevent development of serious RSV disease, it cannot help children already suffering from serious RSV disease and it cannot prevent infection with RSV. There is currently no vaccine to prevent RSV infection, but researchers are working to develop RSV vaccines.

See Handwashing, Infection Control Measures.

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Respiratory Syncytial Virus (RSV) Information: <http://www.cdc.gov/rsv/>

SECTION II—RINGWORM

SIGNS AND SYMPTOMS:

Scalp: Begins as a “pimple” and spreads, leaving scaly patches of temporary baldness.

Skin: Flat, spreading, sores with reddish ring. May be dry and scaly or moist and crusted. Itching is common.

IMMEDIATE INTERVENTION:

Cover exposed sores with a bandage if practical. Refer to a health care provider.

INCUBATION PERIOD:

Scalp: 10–14 days. **Skin:** 4–20 days.

CONTAGIOUS PERIOD:

As long as untreated sores are present until 48 hours after beginning treatment.

TRANSMISSION:

Direct contact with the sores or articles contaminated with the fungus.

Animals including dogs, cats and cattle can be a source of infection.

Ringworm is not caused by a “worm,” it is caused by a **fungus**.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Cover open sores. May attend after treatment begins. The health care provider may recommend anti-fungal preparations which can be purchased without a prescription.

Contacts: Examine close **contacts** and exclude if infected. Parents may seek veterinary assistance in examining and obtaining treatment for infected household pets.

REPORTS REQUIRED:

None required.

SPECIAL FEATURES:

Scalp: Direct contact with hair or hair care items, towels and face cloths should be avoided.

Skin: Launder towels, face cloths and clothing in hot water. Store nap mats so sleeping surfaces do not touch each other. Fungicidal agents must be used on wrestling mats, showers, dressing rooms, sinks, benches and floors in gyms. Assure rapid draining of shower rooms.

See Handwashing, Infection Control Measures, and Parent Alert Letter.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Ringworm information: <http://www.cdc.gov/nczved/divisions/dfbmd/diseases/dermatophytes/>
<http://www.cdc.gov/healthypets/diseases/ringworm.htm>

WebMD: <http://www.webmd.com/skin-problems-and-treatments/tc/ringworm-of-the-skin-topic-overview>

SECTION II—ROSEOLA

SIGNS AND SYMPTOMS:

High **fever** (above 103°) for 3–7 days, irritability, **listlessness** and runny nose may be present. A rash with small, separate, rose-pink spots appears on the chest and abdomen at the time the **fever** disappears. The rash usually lasts only 1–2 days.

IMMEDIATE INTERVENTION:

Exclude individuals with rash accompanied by **fever**.

INCUBATION PERIOD:

9–10 days.

CONTAGIOUS PERIOD:

Unknown.

TRANSMISSION:

Contact with **secretions** from the nose, mouth and throat of an infected person. The **secretions** may be on surfaces or in infected droplets in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until fever-free for 24 hours without the use of fever-reducing medications.

Contacts: No restrictions.

REPORTS REQUIRED:

No reports are required.

SPECIAL FEATURES:

This rash illness is caused by human Herpesvirus 6.

Cases occur throughout the year, mostly in children ages 3 months to 4 years of age. Although roseola is not a serious disease, occasionally seizures occur during the period of high **fever**.

There is no known risk to pregnant women.

Non-aspirin products, like acetaminophen, should be used to reduce **fever**.

See Infection Control Measures, Rash Flow Chart and Features of Rash Illness.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

KidsHealth.org: <http://kidshealth.org/parent/infections/skin/roseola.html>

Mayoclinic.com: <http://www.mayoclinic.com/health/roseola/DS00452>

SECTION II—RUBELLA



(GERMAN MEASLES)

SIGNS AND SYMPTOMS:

Listlessness, low **fever** (101°F), and swollen lymph nodes, accompanied by a fine pink rash beginning on the face and spreading rapidly to the chest and back. Runny nose and joint pain may also be present. Rash and fever typically last 2–3 days.

IMMEDIATE INTERVENTION:

Isolate, exclude and refer to a health care provider for diagnosis. Call the local health department to report all rashes accompanied by **fever**.

INCUBATION PERIOD:

14 to 23 days, commonly 16–18 days.

CONTAGIOUS PERIOD:

From 7 days before to 7 days after the rash appears.

TRANSMISSION:

Contact with **secretions** of the nose, mouth and throat of an infected individual. These **secretions** may be on surfaces, tissues or in infected droplets in the air. Rubella disease is caused by a virus.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude from the time of onset of **fever** and rash, through the 7th day after the rash appears, and until the individual is **fever-free for 24 hours without the use of fever-reducing medications**.

Contacts: Any individual who has not received rubella vaccine or who does not have proof of **immunity** by age-appropriate vaccination or blood test, shall not be permitted to attend school/child care during an **outbreak**, as determined by the local health department.

REPORTS REQUIRED:

Immediate telephone report of **cases** and **suspect cases** to the local health department are required.

SPECIAL FEATURES:

Parents should alert the health care provider of any rash-illness before transporting the child to a health care facility.

Rubella can have serious consequences for the fetus of a pregnant woman. If pregnant and exposed to rubella, consult a health care provider immediately.

Rubella **immunization** is not recommended during pregnancy.

Review histories of all individuals to identify need for immunization updates and/or exclusion. Individuals should be considered immune to rubella only if they have documentation of one of the following:

- **Immunization** with rubella vaccine on or after the first birthday;
- Those who have a positive blood test (titer) demonstrating immunity.

All other individuals should be considered **susceptible** and should be vaccinated if there are no contraindications.

MMR and MMRV vaccines include protection against Rubella, as well as Measles, Mumps and Varicella (in MMRV) and two doses of this vaccine are a part of the routine children's immunization schedule.

SECTION II—RUBELLA



(GERMAN MEASLES)

Rubella is also known as German measles or 3-day measles.

See Handwashing, Rash Flow Chart, and Features of Rash Illness, Immunizations and Parent Alert Letter.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Rubella (German Measles) information: <http://www.cdc.gov/vaccines/vpd-vac/rubella/in-short-adult.htm>
<http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mmr.pdf>

WebMD: <http://children.webmd.com/tc/rubella-german-measles-topic-overview>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding) <http://www.mothertobaby.org/otis-fact-sheets-s13037> (MMR Vaccine) (Fact Sheets in English and Spanish)

SECTION II—SCABIES

O

SIGNS AND SYMPTOMS:

Intense itching of the skin, especially at night.

Small blister-like sores or tiny burrows (short, wavy, dirty-looking lines) that contain the mites and their eggs. These sores and burrows are seen commonly around finger webs, creases of the wrists and elbows, belt line, and genitals of men and lower buttocks of women. In infants, the head, neck, palms, soles and buttocks may also be involved.

IMMEDIATE INTERVENTION:

Exclude and refer to a health care provider.

INCUBATION PERIOD:

From 2–6 weeks before itching is noticed. If previously infected, 1–4 days before symptoms are noticed.

CONTAGIOUS PERIOD:

As long as live mites are present.

TRANSMISSION:

Usually by direct skin-to-skin contact. Spread by contact with **infested** clothing and bed linen is possible. The mite can survive off the body for only 2–3 days.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until treatment has been completed (usually overnight).

Contacts: All **household contacts** should be treated at the same time as the **infested** individual. Examine close contacts and refer for treatment if infested.

REPORTS REQUIRED:

Immediate reports of **outbreaks** in schools and child care are required.

SPECIAL FEATURES:

Occasionally, 2 treatments one week apart may be required to eliminate the **infestation**.

Itching may continue for weeks after treatment is complete.

Scratching may result in bacterial skin infections.

Environmental pesticide sprays are not recommended for management.

Wash and dry, on the hot cycle, all washable items that the individual may have come into contact with in the previous 3 days. Include bed linens, towels and clothes.

Mites can burrow under the skin in 2 minutes.

See Rash Flow Chart and Parent Alert Letter.

SECTION II—SCABIES

O



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Scabies information: <http://www.cdc.gov/parasites/scabies/>

WebMD: <http://www.webmd.com/skin-problems-and-treatments/tc/scabies-topic-overview>
<http://www.webmd.com/hw-popup/return-to-school-after-scabies-treatment>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding) <http://www.mothertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION II—SEXUALLY TRANSMITTED DISEASES

All child care providers and teachers should receive education on recognizing and reporting child abuse, including physical, sexual, and psychological or emotional abuse and neglect. The possibility of sexual abuse must be considered when children develop diseases commonly transmitted sexually. The person making the report does not need to prove the abuse. Investigation and validation of child abuse reports are the responsibilities of child protection authorities and law enforcement personnel.

Arizona Child Abuse Hotline at 1-888-SOS-CHILD (1-888-767-2445) or law enforcement.

CHLAMYDIA

SYMPTOMS:

Discharge from vagina or penis, and/or rectum; pain on urination; lower abdominal pain; symptoms can cause develop in the throat

TRANSMISSION:

From infected mom to infant during childbirth (vaginal delivery); also spread through vaginal, oral and/or anal sex with infected individual

INCUBATION:

Symptoms may occur 1–3 weeks after exposure; infections can persist for months; frequently no symptoms

COMMUNICABLE PERIOD:

No longer contagious after 7 days on prescribed antibiotic

SCHOOL/CHILD CARE:

Exclusion from school is not recommended; treatment with prescribed antibiotics is recommended

GENITAL WARTS

SYMPTOMS:

Small, bumpy warts on the sex organs and/or anus that can cause itching or burning; the warts may go away, remain unchanged or grow and spread

TRANSMISSION:

Spread by direct contact with an infected person, even when the infected person is not symptomatic

INCUBATION:

1–20 months, average 2–3 months; most people do not develop symptoms

COMMUNICABLE PERIOD:

Spread when infected person is symptomatic or asymptomatic

SCHOOL/CHILD CARE:

No exclusion; a health care provider can determine if removal of warts is recommended

SECTION II—SEXUALLY TRANSMITTED DISEASES

GONORRHEA

SYMPTOMS:

Discharge from vagina or penis, and/or rectum; pain on urination; lower abdominal pain; symptoms can also develop in the throat

For Newborns: Discharge from the eyes; in older female children, vaginal discharge, burning or urination may occur; in older male children, discharge from penis and burning on urination may occur; may be no symptoms

TRANSMISSION:

From infected mom to infant during vaginal delivery; also spread through vaginal, oral and/or anal sex with infected individual; in older children through sexual transmission

INCUBATION:

Symptoms may appear 1–14 days after infection

COMMUNICABLE PERIOD:

No longer contagious after 7 days on prescribed antibiotic

SCHOOL/CHILD CARE:

Exclusion from school is not recommended; treatment with prescribed antibiotics is recommended

HERPES

SYMPTOMS:

Small, painful blisters on the sex organs or mouth (cold sores); blisters last 1–3 weeks; blisters can come back; flu-like symptoms, fever and swollen glands may be present

TRANSMISSION:

Spread by direct contact with infected person, even when the infected person has no symptoms

INCUBATION:

Symptoms may show within two weeks after exposure

COMMUNICABLE PERIOD:

Spread when infected person is symptomatic or has no symptoms

SCHOOL/CHILD CARE:

Exclude if fever blisters are in the mouth or on the lip and cannot control drooling; for others, cover sores with a bandage if possible

SECTION II—SEXUALLY TRANSMITTED DISEASES

SYPHILIS

SYMPTOMS:

1st Stage: one or more painless sores at site of infection

2nd Stage: a rash anywhere on the body, typically found on hands and feet and/or trunk of body; other symptoms are loss of hair, mucous patches in mouth, or wart-like lesions in genital area

TRANSMISSION:

Spread by direct contact with lesions

INCUBATION:

10–90 days; average 21 days

COMMUNICABLE PERIOD:

Contagious when initial sore is present and possibly through mucous patches in the mouth or warty-growths in the genital area

1st Stage: 1–5 weeks

2nd Stage: 2–6 weeks

SCHOOL/CHILD CARE:

Exclusion from school not recommended; treatment with prescribed antibiotics is needed

BACTERIAL VAGINOSIS (NOT ALWAYS SEXUALLY TRANSMITTED)

SYMPTOMS:

Itching, burning or pain in the vaginal area; unpleasant odor; burning during urination; itching around the vagina; may be no symptoms

TRANSMISSION:

Spread by direct contact; bacterial vaginosis is not always sexually transmitted; there are other causes of the infection such as pregnancy, antibiotics, menstruation, douching, and diabetes

INCUBATION:

Variable

COMMUNICABLE PERIOD:

Spread when infected person is symptomatic or has no symptoms

SCHOOL/CHILD CARE:

Exclusion from school is not recommended; treatment with prescribed medication is recommended

HEPATITIS B & HIV/AIDS

See Resource Guide pages 32 and 36

SECTION II—SEXUALLY TRANSMITTED DISEASES

IMMEDIATE INTERVENTION:

Refer to health care provider for diagnosis and treatment.

REPORTS REQUIRED:

Health care providers are required to report syphilis, gonorrhea, chlamydia, genital herpes and hepatitis B.

SPECIAL FEATURES:

Except in the case of hepatitis B, the potential relationship between sexually transmitted diseases and sexual abuse in children cannot be ignored.

Health education regarding sexually transmitted diseases (S.T.D.'s) including **signs**, **symptoms** and how they are spread should be included in the age-appropriate human development curriculum.

Treatment of STDs is available through local health department and other clinics, and through private health care providers.

Arizona State law allows minors to obtain treatment of STDs without parental consent.

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Sexually Transmitted Diseases information: <http://www.cdc.gov/std/default.htm>

<http://www.cdc.gov/std/treatment/2010/sexual-assault.htm>

Arizona Department of Economic Security: <https://www.azdes.gov/dcyf/cps/reporting.asp>

SECTION II—STREPTOCOCCAL SORE THROAT & SCARLET FEVER

O

SIGNS AND SYMPTOMS:

Strep Throat: Typically, sudden onset of red sore throat, **fever**, **listlessness**, swollen glands, **nausea** and headache. Tongue may be coated white and then become bright red.

Scarlet Fever: As above, with a fine sandpaper-like rash usually beginning on the chest and back and spreading to all parts of the body including the hands and feet. The rash clears in about 1 week and peeling of the skin is common.

IMMEDIATE INTERVENTION:

Isolate, exclude and refer to health care provider for diagnosis and treatment. Call the local health department to report all undiagnosed rashes accompanied by fever.

INCUBATION PERIOD:

2–5 days.

CONTAGIOUS PERIOD:

Untreated, 10–21 days. Treated with **antibiotics**, up to 24 hours after first dose.

TRANSMISSION:

Contact with **secretions** of the nose, mouth and throat of an infected individual. These **secretions** may be on surfaces or in infected droplets in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude for at least 24 hours after the first dose of **antibiotics** and the individual is fever-free for 24 hours without the use of fever-reducing medications.

Contacts: Observe for early **signs** and **symptoms** of illness.

REPORTS REQUIRED:

Outbreak reports required.

SPECIAL FEATURES:

Scarlet fever is the result of a toxin produced by certain kinds of streptococcal bacteria. Treatment is usually the same as for “strep throat.” Streptococcal bacteria are responsible for other infections such as impetigo, and ear infections. Most children who do not receive treatment will recover however some may develop complications such as ear and sinus infections. Some may develop serious damage to the kidneys or heart (rheumatic heart disease). Infections are usually seasonal, with most cases in the winter months. Dispose of tissues immediately after one use; use face cloths one time and on only one individual before laundering.

See Handwashing, Rash Flow Chart, Features of Rash Illness, Infection Control Measures, and Parent Alert Letter.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Streptococcal Sore Throat and Scarlet Fever information: <http://www.cdc.gov/Features/ScarletFever/>

KidsHealth.org: http://kidshealth.org/parent/infections/bacterial_viral/scarlet_fever.html
http://kidshealth.org/parent/infections/lung/strep_throat.html#

SECTION II—THRUSH/YEAST DIAPER RASH

SIGNS AND SYMPTOMS:

Thrush: Creamy white patches resembling cottage cheese curds inside the mouth and on the tongue. When scraped, these spots leave a raw, bleeding, painful sore. Seen most often in infants and **immunocompromised** individuals.

Yeast Diaper Rash: Bright red rash in the diaper area. The infected skin may peel or develop open sores.

IMMEDIATE INTERVENTION:

If **signs** and **symptoms** are present, refer to a health care provider for management which may include medication.

INCUBATION PERIOD:

Variable; 2–5 days for thrush in infants.

CONTAGIOUS PERIOD:

While sores are present.

TRANSMISSION:

Thrush: Contact with secretions from the mouth and throat of an infected individual.

Yeast Diaper Rash: Contact with the skin and stool of an infected individual.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Children who are being treated with medication prescribed or recommended by a health care provider for thrush or yeast diaper rash do not need to be excluded.

Contacts: No restrictions.

REPORTS REQUIRED:

None. If there is an unusual infection rate (3 or more individuals in a classroom with Thrush or Yeast diaper rash) notify the local health department for additional management steps.

SPECIAL FEATURES:

Both Thrush and Yeast diaper rash are caused by various kinds of Candida yeast.

When caring for children with thrush, special attention must be given to items contaminated with the saliva of infected children such as bottles, feeding utensils, pacifiers, mouthed toys, bibs and clothing wet with drool, and medication implements. Pay special attention to cleaning and sanitizing mouthed items and equipment that belongs to the facility.

Place the child's personal items in a plastic bag, label with the child's name and send home for cleaning. Make sure the child's bottle and pacifier are labeled and not "shared" with another child.

Children with yeast diaper rash must have their diapers changed immediately after they become wet or soiled.

The child's bottom should be cleaned with soap and water, rinsed well, and gently patted dry. Avoid the use of corn starch, powders, ointments, and diaper wipes containing alcohol as they can further irritate the skin and cause discomfort. Use only the ointments or medications recommended or prescribed by the child's health care provider. Clean and sanitize diaper changing surfaces well.

Careful handwashing after contact with affected areas, secretions, or items contaminated with secretions is important.

See Handwashing, Infection Control Measures.

SECTION II—THRUSH/YEAST DIAPER RASH



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

HealthyChildren.org:

<http://www.healthychildren.org/English/health-issues/conditions/infections/pages/Thrush-and-Other-Candida-Infections.aspx>

Diaper Changing Procedures: Caring for Our Children: National Health and Safety Performance Standards Guidelines for Early Care and Education Programs, 3rd Edition: <http://cfoc.nrckids.org/StandardView/3.2.1.4>

SECTION II—TUBERCULOSIS



(PULMONARY)

SIGNS AND SYMPTOMS:

Cough, low fever, weight loss, night sweats, chest pain. The cough may produce bloody **sputum**. There may be no **symptoms**, particularly in children and adolescents.

IMMEDIATE INTERVENTION:

Refer to a health care provider for diagnosis and treatment.

INCUBATION PERIOD:

May be from months to a lifetime. The time from infection to development of a positive tuberculin skin test or identification of disease on X-ray may range from 2–10 weeks.

CONTAGIOUS PERIOD:

As long as living bacteria are in the **sputum**.

TRANSMISSION:

Breathing in infected droplets that come from the nose, mouth and throat of an infected individual. These droplets are transmitted through the air when infected persons exhale, cough, sneeze, talk, laugh, or sing. The infected droplets are then breathed in by other individuals. Infants and young children are usually not contagious. Risk is greatest for individuals sharing airspace for prolonged period of time.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Exclude until laboratory examination of **sputum** demonstrates tuberculosis bacteria are no longer present or according to more specific guidelines established by the local health department.

Contacts: The local health department will assist in completing investigation and screening of **household**, school and child care **contacts**. The local health department will provide information regarding management guidelines for TB.

REPORTS REQUIRED:

Case and **suspect case** reports are required within 1 working day.

SPECIAL FEATURES:

In areas where TB is prevalent, skin testing will identify individuals who may be infected. Foreign-born adults and children show increased rates of infection, as do individuals with HIV infection, close contacts of individuals with TB infection, and residents of long-term care facilities. Communities may also identify specific groups in their area where an increased rate of tuberculosis exists (e.g., homeless populations or migrant farm workers). Group care programs may contact their local health department for advice on developing health policies regarding tuberculosis testing for staff, volunteers, and children. The TB skin test is a screening test—not an **immunization** against tuberculosis.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Tuberculosis (Pulmonary) Information: <http://www.cdc.gov/tb/>

KidsHealth.org: <http://kidshealth.org/parent/infections/lung/tuberculosis.html>

SECTION II—VALLEY FEVER

(COCCIDIOIDOMYCOSIS)

SIGNS AND SYMPTOMS:

Infection may go unnoticed or resemble a mild cold. **Symptoms** often include cough, **fever**, chills, backache, headache, **listlessness** and chest pain.

Sometimes a light rash or swollen lymph nodes are present.

Early **signs** and **symptoms** of Valley fever can imitate other respiratory conditions or illnesses.

IMMEDIATE INTERVENTION:

Refer to a health care provider for evaluation and diagnosis.

INCUBATION PERIOD:

From 1–4 weeks.

CONTAGIOUS PERIOD:

Not contagious (not spread person-to-person).

TRANSMISSION:

Inhaling **fungus** spores from the soil, most commonly from dust in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: No restrictions.

Contacts: No restrictions.

REPORTS REQUIRED:

Health care providers are required to report cases and suspect cases.

SPECIAL FEATURES:

- Knowledge of Valley Fever will be helpful in answering questions of parents.
- Valley Fever is common in Arizona.
- Dust reduction measures should be considered for desert gatherings, construction sites, dirt roads, off-road recreation and in farming communities.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Valley Fever (Coccidioidomycosis) Information:

<http://www.cdc.gov/nczved/divisions/dfbmd/diseases/coccidioidomycosis/>

SECTION II—WHOOPIING COUGH



(PERTUSSIS)

SIGNS AND SYMPTOMS:

Mild, cold-like **signs** and **symptoms** accompanied by little or no **fever**.

Coughing, which gets worse within 1–2 weeks and often results in severe fits of coughing that can result in difficulty breathing. After episodes of coughing, vomiting may occur. The cough may be followed by a “whooping sound” in older infants and preschool children.

IMMEDIATE INTERVENTION:

Isolate and exclude. Refer to a health care provider for diagnosis and treatment.

INCUBATION PERIOD:

6 to 21 days, usually 7–10 days.

CONTAGIOUS PERIOD:

Most contagious during the cold-like stage to 3 weeks after the cough begins, or until on effective **antibiotic** therapy for a minimum of 5 days.

TRANSMISSION:

Contact with **secretions** of the nose, mouth and throat of an infected individual. These **secretions** may be on surfaces or in infected droplets in the air.

SCHOOL/CHILD CARE ATTENDANCE:

Cases: Untreated individuals must be excluded for 3 weeks following the onset of severe coughing. Individuals treated with an appropriate antibiotic (Azithromycin, Erythromycin, Clarithromycin, TMP/SMZ) may return in 5 days if their condition allows and they are **fever-free for 24 hours without the use of fever-reducing medications**.

Contacts: A preventive course of an appropriate antibiotic for **household contacts** and close **contacts** as identified by the local health department during the course of the contact investigation. The local health department will assist in investigating and prescribing a course of action for group settings.

REPORTS REQUIRED:

Immediate telephone report of **cases** and **suspect cases** to the local health department are required.

SPECIAL FEATURES:

Whooping Cough (Pertussis) is a **vaccine**-preventable disease.

Review immunization histories of all children to identify those who need additional vaccination when a **case** occurs in the group setting.

Immunity provided by vaccinations begins to diminish during the teenage years, making teens and adults **susceptible** to whooping cough again.

Whooping Cough vaccine combined with tetanus and diphtheria toxoids (Tdap) is given routinely during early childhood and is now recommended for these individuals:

- Adolescents should receive a one-time dose of Tdap (instead of Td) at the 11–12-year-old visit.
- Adolescents and adults younger than age 65 years who have not received a dose of Tdap, or for whom vaccine status is unknown, should be immunized with Tdap as soon as possible regardless of when the last tetanus vaccine was given.

SECTION II—WHOOPING COUGH



(PERTUSSIS)

- Adults age 65 years and older who have not previously received a dose of Tdap, and who have or anticipate having close contact with children younger than age 12 months (e.g., grandparents, other relatives, child care providers, and health-care personnel), should receive a one-time dose of Tdap to protect infants, regardless of when the last tetanus vaccine was given.
- Other adults 65 years and older who are not in contact with an infant, and who have not previously received a dose of Tdap, may receive a single dose of Tdap in place of a dose of Td.
- Children ages 7–10 years who are not fully immunized against pertussis (did not complete a series of pertussis-containing vaccine before their seventh birthday) should receive a one-time dose of Tdap.

Whooping cough is often misdiagnosed as bronchitis, or other respiratory illness in teens and adults.

See Immunization Schedule, Infection Control Measures and Parent Alert Letter.

**ADDITIONAL INFORMATION:**

(Links below were deemed reliable information at the time of publication)

CDC Pertussis (Whooping Cough) Information: <http://www.cdc.gov/pertussis/>

Office of Teratology Information Specialists (exposures to drugs and diseases during pregnancy and breastfeeding): <http://www.mothertobaby.org/otis-fact-sheets-s13037> (Fact Sheets in English and Spanish)

SECTION III

SECTION III—HANDWASHING STEPS

WASH YOUR HANDS!



Handwashing is a disease prevention practice which must be done correctly and at appropriate times to be effective.

- Handwashing should be carried out with a good lather for 20 seconds;
- Young children must be reminded to wash their hands at appropriate times;
- Young children must be monitored for correct handwashing steps to ensure effectiveness;
- All diapered children, regardless of age, must have their hands washed after diapering. Use all steps;
- Moistened towelettes are NOT recommended for routine handwashing practices; however they may be used in the absence of soap and water, such as a field trip or for quick removal of dirt and sticky substances.

SECTION III—HANDWASHING STEPS**SUPPLIES INCLUDE:**

- Warm, running, water, with “mixit” type faucets;
- Sinks that drain quickly, and completely;
- Liquid soap, wall-mounted or pump;
- Single-use disposable paper towels, or commercial hand-drying blowers;
- Plastic-lined trash container for soiled paper towels;

APPROPRIATE HANDWASHING TIMES INCLUDE:**ADULTS**

- When you arrive at the program/school;
- Before and after first aid or temperature-taking;
- Before and after preparing foods, snacks, or bottles;
- Before and after giving medications;
- After using the toilet or helping a child to use the toilet;
- After diapering a child;
- After you handle items soiled with waste or body fluids such as, urine, saliva, stool, blood or discharge from the eyes, nose, or sores;
- After prolonged sneezing or coughing;
- After caring for a sick child or animals;
- After messy activities;

CHILDREN

- When they arrive at the program/school;
- Before eating meals and snacks;
- After their diaper is changed;
- After they use the toilet;
- After playing with animals and pets;
- After outdoor play;
- After prolonged coughing, sneezing, or wiping their nose;
- After messy activities.

HAND SANITIZERS

- Use when soap and water are not available;
- Not effective when hands are visibly soiled;
- Only use for children over 24 months of age;
- Not effective when hands are visibly soiled;
- A small amount should be placed on the hands;
- Hands should be rubbed together spreading the sanitizer to all surfaces including between the fingers;
- Allow hands to air dry;
- Sanitizers should contain at least 60% alcohol;
- Supervise young children’s use of hand sanitizers and store out of their reach.

SECTION III—INFECTION CONTROL MEASURES

HANDWASHING

Supplies include warm, running water, liquid soap, and disposable, single use paper towels or commercial hand blowers.

- Wash the fronts, backs and between the fingers with soap and gentle pressure (friction) for 20 seconds.
- Dry hands completely with a single use paper towel or commercial hand blower.
- Handwashing guidelines apply to infants, children, and adults who have experienced potential exposure.
- Alcohol-based hand sanitizing solutions may be used by adults and supervised children over the age of two following handwashing to kill germs which remain or if soap and water are not available.

WASH HANDS BEFORE:

- Preparing/serving food, snacks or bottles.
- Eating food, snacks.
- Giving medication or taking temperatures
- Cleaning wounds or changing bandages.
- Changing diapers.
- Doing any medical or invasive procedure.
- Beginning activities that involve food.

WASH HANDS AFTER:

- **ANY** contact with stool, urine, vomit, mucus, pus, blood or body fluid.
- Playing with pets, animals or birds.
- Changing a diaper.
- Changing a bandage or tending wounds.
- Tending to a sick child (person).
- Using the toilet.
- Messy activities.
- Playing outside, in sandboxes, on equipment, etc.

REMEMBER:

- Handwashing areas must be regularly re-supplied.
- Young children must be monitored and reminded of handwashing steps each day.
- Diapered age children must have their hands washed for them, especially after diapering.
- Moistened towelettes are not recommended for routine handwashing. They may be used in the absence of running water and soap, for field trips or for a quick clean-up of soil, grime or sticky substances.

RISK OF DISEASE INCREASES WHEN HANDS ARE DIRTY OR CONTAMINATED!

GLOVES

Latex or vinyl single-use non-porous gloves are to be used by individuals performing tasks which may bring them into contact with disease-causing germs.

SECTION III—INFECTION CONTROL MEASURES

WEAR GLOVES FOR HIGH RISK PROCEDURES SUCH AS:

- Cleaning up vomit, stool, blood, urine, pus, and body fluids or secretions.
- Changing bandages, especially if blood, pus or signs of infection are present.
- Cleansing or controlling bleeding wounds, or broken skin, such as nosebleeds, tooth loss, and cuts, scrapes, etc.
- Changing diapers, especially with loose stools.
- Handling linens, clothing, diapers, equipment or surfaces that have been soiled with blood, vomit, stool, urine or body fluids.

GLOVING GUIDELINES:

- Gather all supplies and equipment before putting gloves on.
- Remove gloves immediately after completing tasks by peeling them off of hands, turning gloves inside out and discarding.
- After removing gloves, proceed with tasks of re-diapering, re-bandaging, replacing supplies, etc.
- Discard visibly contaminated and potentially contaminated gloves into a separate, closed plastic bag before disposal into a plastic-lined trash receptacle.
- Wash your hands before moving to any other activity.

GLOVING REMINDERS:

- Care must be taken to prevent contaminated gloves from infecting others or the environment.
- Gloves used for infection control procedures must be discarded immediately. They must be single use, disposable gloves. NEVER re-use these gloves!
- Utility gloves may be used for general cleaning activities and can be washed and sanitized for re-use. These gloves are a heavier, sturdier glove made of a rubber-type material.

SANITATION/DISINFECTING

Cleaning removes soil, debris and oils and reduces the number of germs using soaps, detergents, or cleaners.

Sanitizing reduces but does not eliminate germs on inanimate surfaces to levels considered safe by public health standards.

Disinfecting kills or inactivates germs (but not spores) on objects or surfaces. This can involve the use of chemicals or very high heat.

- Items or surfaces must be cleaned before sanitizing or disinfecting.
- **Facility-approved disinfecting solutions** may be preferred over bleach solutions. However, care must be taken to prevent toxic substances from accumulating or remaining on items which may go into the mouth.
- During outbreaks of norovirus in the community, the local health department may stress the importance using EPA-registered bleach products for disinfecting in the group setting.
- Sponges are not recommended for sanitizing activities.
- Dishwashers clean items, and can assist in the sanitizing process if the water temperature is hot enough, the water pressure is adequate, and the cycle length is appropriate.

BLEACH AND WATER SOLUTIONS

EPA-registered bleach products are described as sanitizers and disinfectants (not “laundry bleach”). Check the label to see if the product has an EPA registration number and follow the manufacturer’s safety and use instructions. Never mix bleach with other cleaners or chemicals. Always label containers with the contents.

SECTION III—INFECTION CONTROL MEASURES

Follow state or local recommendations and/or manufacturer's instructions for creating solutions to sanitize or disinfect surfaces. A weak concentration of bleach may make the mixture ineffective; however, using too much (a strong concentration) bleach may create a potential health hazard.

- Select a bottle made of opaque material.
- Make a fresh bleach dilution daily; label the bottle with contents and the date mixed.
- Wear gloves and eye protection
- Use a funnel to avoid spills.
- Add bleach to water to reduce fumes.
- Make sure the room is well ventilated.
- Store out of reach of children.

LAUNDRY

Fabrics contaminated with blood, stool, vomit, pus, mucus or other body fluid must be laundered separately from general laundry.

- Bag contaminated laundry where it became soiled. Do not carry unbagged contaminated laundry across the facility to the laundry room.
- All clothing which has been soiled with urine, vomit, stool, blood or other body fluid must be placed into a separate plastic bag, labeled with the owner's name and sent home for laundering.
- Store the contaminated, labeled, laundry bags in a separate plastic lined receptacle until laundry is picked up by parents, laundry service or laundered at the program site. Do not place in cubbies or diaper bags, as these areas often contain clean items, food and/or bottles.
- Wash contaminated laundry in hot water (165N) for 20 minutes.
- Add an EPA-registered bleach product for sanitizing and disinfecting according to the manufacturer's safety and use instructions to the washer along with laundry detergent in a regular wash cycle.
- Add an EPA-registered bleach product for sanitizing and disinfecting according to the manufacturer's safety and use instructions to sink solutions.
- Automatic clothes dryers on hot settings and direct sunlight assist in the germ killing process.

BAGGING

Items which are visibly contaminated or potentially infectious must be separated from the general trash and placed into a separate, closed (tied off or taped) plastic bag.

- Before bagging, bulk stool or vomit may be discarded into the toilet. DO NOT rinse, shake, wring or dunk items
- Disposable diapers, diaper wipes, gloves, bandages, paper towels used to clean contaminated areas, etc., must be placed into a plastic bag and sealed before disposal into the general trash
- All paper towels, bandages, cotton, gauze, gloves, etc., used for any type of bleeding injury and sanitary napkins, must be discarded into a separate sealed, plastic bag before discarding into a plastic-lined trash receptacle

OTHER WASTE:

- All contaminated syringe needles, blades, broken glass, must be discarded in an appropriate penetration-resistant container.
- Discard waste in compliance with state and local guidelines.

SECTION III—ARIZONA IMMUNIZATION REQUIREMENTS

2014–2015 ARIZONA SCHOOL IMMUNIZATION REQUIREMENTS, KDG–12TH GRADE

- Students must have proof of all required immunizations, or a valid exemption, in order to attend school. Arizona law allows exemptions for medical reasons, lab evidence of immunity, and personal beliefs. Exemption forms are available from schools and at <http://azdhs.gov/phs/immunization/school-childcare/requirements.htm>. Homeless students are allowed a 5-day grace period.
- The immunization record for each vaccine dose must include the date and the doctor or clinic name.
- The statutes and rules governing school immunization requirements are:
Arizona Revised Statutes 15-871-874; Arizona Administrative Code, R9-6-701–708.

Please check requirements for each child's age and grade level in the chart below.

Vaccine	Age	Under Age 7	7–10 years	11 years and older
	Grade	Kindergarten and Above	Kindergarten–5 th Grades	6 th through 12 th Grades
DTaP/DTP/DT		4–5* doses; at least 1 dose at 4 years of age or older is required *A 6 th dose is required if 5 doses have been given before 4 years of age	3 DTaP, DTP, DT and/or Td doses are required if all doses were given after 12 months of age or 4 DTaP, DTP, DT and/or Td doses are required if dose #1 was given before 12 months of age	1 Tdap dose is required for students 11 and older Exception: students who have completed the primary series of at least 3–4 doses of DTaP/DTP/DT/Td are not required to receive Tdap until 5 years have passed since their last dose of DTaP/DTP/DT/Td
Td			Tdap may be counted to meet the requirements above. Tdap is not required for 11 year olds until they enter 6 th grade	Tdap doses given prior to age 11 meet this requirement
Tdap				A Td booster is required 10 years after the Tdap dose
Meningococcal			Not required Doses given at age 10 meet the requirement for 11 year olds	1 dose is required for students 11 years and older
Polio		3–4 doses 3 doses meet the requirement if the 3 rd dose was given at 4+ years of age. 4 doses meet the requirement even if all 4 doses were given in the first year of life. (Not required for age 18 and older.)		
MMR		2 doses A 3 rd dose will be required if dose #1 was given before more than 4 days before the child's 1 st birthday.		
Hepatitis B		3 doses A 4 th dose will be required if the third dose was given before 24 weeks of age.		
Varicella		1 dose is required if the 1st dose was given before 13 years of age 2 doses are required if the 1st dose was given at 13 years of age or later Students attending school or preschool in Arizona prior to 9/1/2011 with parental recall of chickenpox disease are allowed to continue attendance with parental recall of disease. Students enrolling in an Arizona preschool or school for the first time are 9/1/2011 are required to present proof of varicella immunization or a valid exemption for medical reasons, laboratory evidence of immunity or personal beliefs.		

Note: ADHS observes a 4-day grace period for vaccine ages and intervals, except for the space between two live vaccines such as Varicella and MMR, which must be given at least 28 days apart if they are not administered on the same day.

Childcare and preschool immunization requirements are posted at <http://azdhs.gov/phs/immunization/school-childcare/requirements.htm>. Arizona Immunization Program Office • 150 North 18th Avenue, Suite 120 • Phoenix, AZ 85007 • (602) 364-3630 • Toll-free (866) 222-2329 4/9/2014



COMMUNICABLE DISEASE RESOURCE GUIDE

AZDHS.GOV

SECTION III—ARIZONA IMMUNIZATION REQUIREMENTS

ARIZONA IMMUNIZATION REQUIREMENTS FOR BIRTH TO 5 YEARS CHILDCARE, PRESCHOOL AND KINDERGARTEN IN 2013–2014

Because children who attend child care are at greater risk of exposure to illness, Arizona state law requires that some immunizations be completed at the beginning of the age range listed on the recommended immunization schedule found at <http://www.cdc.gov/vaccines/recs/schedules>. Exceptions, minimum intervals and a “catch up” schedule are on the back of this handout. Updates to these requirements will be posted at <http://www.azdhs.gov/phs/immun/back2school.htm>.

AT BIRTH

Hep B #1

Note: Hep B #1 is the only shot babies under 2 months must have for childcare.

REQUIRED AT 2 MONTHS

DTaP #1

Polio #1

Hib #1

REQUIRED AT 4 MONTHS

DTaP #2

Polio #2

Hib #2

Hep B #2

REQUIRED AT 6 MONTHS

DTaP #3

Hib #3*

*If Pedvax Hib or Comvax is used, the 3rd dose of Hib is not due until 12–15 months of age.

REQUIRED AT 12 MONTHS

Polio #3

Hep B #3*

MMR #1**

Varicella¹ #1***

*If Hep B #3 was given before 24 weeks of age, a 4th dose is needed.

****Note:** MMR and Varicella must be given on the same day or at least 28 days apart.

*****(Chickenpox Vaccine)** Note: MMR and Varicella must be given on the same day or at least 28 days apart.

REQUIRED AT 15 MONTHS

DTaP #4

Hib #4 (Booster)*

*Hib #4 is not needed if Hib #3 is given at/after 12 months of age. A Hib dose at/after 12 months is required for all children under 5 years. One Hib dose given at/after 15 months of age meets the Hib requirement regardless of the total number of Hib doses received.

SECTION III—ARIZONA IMMUNIZATION REQUIREMENTS

SUMMARY OF VACCINES REQUIRED FOR ALL CHILDREN 15–24 MONTHS OF AGE

All of these doses are required as of 15 months of age: 4 DTaP, 3 Polio, 1 MMR, 1 Varicella¹, 3 Hep B and 3–4 Hib (with 3rd or 4th dose on/after 1st birthday) or 1 Hib dose given at/after 15 months. (Hepatitis A is required for 1 through 5 year olds in Maricopa County only.)

SUMMARY OF VACCINES REQUIRED FOR ALL CHILDREN 2–5 YEARS OF AGE

Must have 4 DTaP, 3 Polio, 1 MMR, 1 Varicella¹, 3 Hep B and 3–4 Hib (with 3rd or 4th dose on/after 1st birthday) or 1 Hib dose given at/after 15 months.(+2 doses of Hepatitis A in Maricopa County only.)

5+ YEARS IN KINDERGARTEN

At kindergarten entry must have 5 DTaP*, 4 Polio*, 2 MMR, 1 Varicella¹ & 3 Hep B. (Hepatitis A is not required for kindergarten.) *Children who received DTaP #4 and/or Polio #3 on/after the 4th birthday do not need additional doses to enter kindergarten.

¹Parental recall of chickenpox disease is accepted only for children who enrolled in childcare before 9/1/2011.

SECTION III—REQUIREMENT EXCEPTIONS & ADDITIONS

EXCEPTIONS AND ADDITIONS TO THE RULES

Parents whose religious beliefs do not allow immunization must sign a **religious exemption** form. A **medical exemption** form must be signed by the child's doctor if there is lab evidence of immunity or a medical reason why the child cannot receive shots. A copy of the lab results must be kept on file to prove the child's immunity.

A child who is missing shots required for his age can start childcare but must get a dose of each shot due within 15 days of enrollment **and** bring a copy of the shot record completed by the clinic to the child care setting. **After 15 days, the child may not attend without documentation of these shots.**

CATCH UP SCHEDULE (FOR CHILDREN MISSING IMMUNIZATIONS):

DTAP

The 2nd dose is due 1–2 months after the 1st dose; the 3rd dose is due 1–2 months after the 2nd dose; the 4th dose is due 6 months after the 3rd dose.

POLIO

The 2nd dose is due 1–2 months after the 1st dose; the 3rd dose is due 1–2 months after the 2nd dose. (If the child is 4+ years of age, the 3rd Polio may qualify as the child's final dose and a 6-month space is recommended between the last two Polio doses.)

HEP B

The 2nd dose is due 1–2 months after the 1st dose; the 3rd dose is due 3–4 months after the 2nd dose. If Hep B #3 was given before 24 weeks of age, a 4th dose is needed.

HIB

If child is less than 1 year, doses are given 2 months apart. If child is at least 15 months old and less than 5 years, a single dose is needed to catch up.

MMR*

The 1st dose is required at 12 months of age. A 2nd dose is required for kindergarten entry.

VARICELLA*

The 1st dose is required at 12 months of age. **Parental recall of chickenpox disease is accepted only for children who enrolled before 9/1/2011. All other children must have proof of immunization or a valid exemption for lab evidence of immunity, medical reasons or religious beliefs.**

HEP A

Children 1 through 5 years of age in **Maricopa County only** are required to obtain dose #1 within 15 days of enrollment in child care, preschool or Head Start. Dose #2 is due 6 months after dose #1.

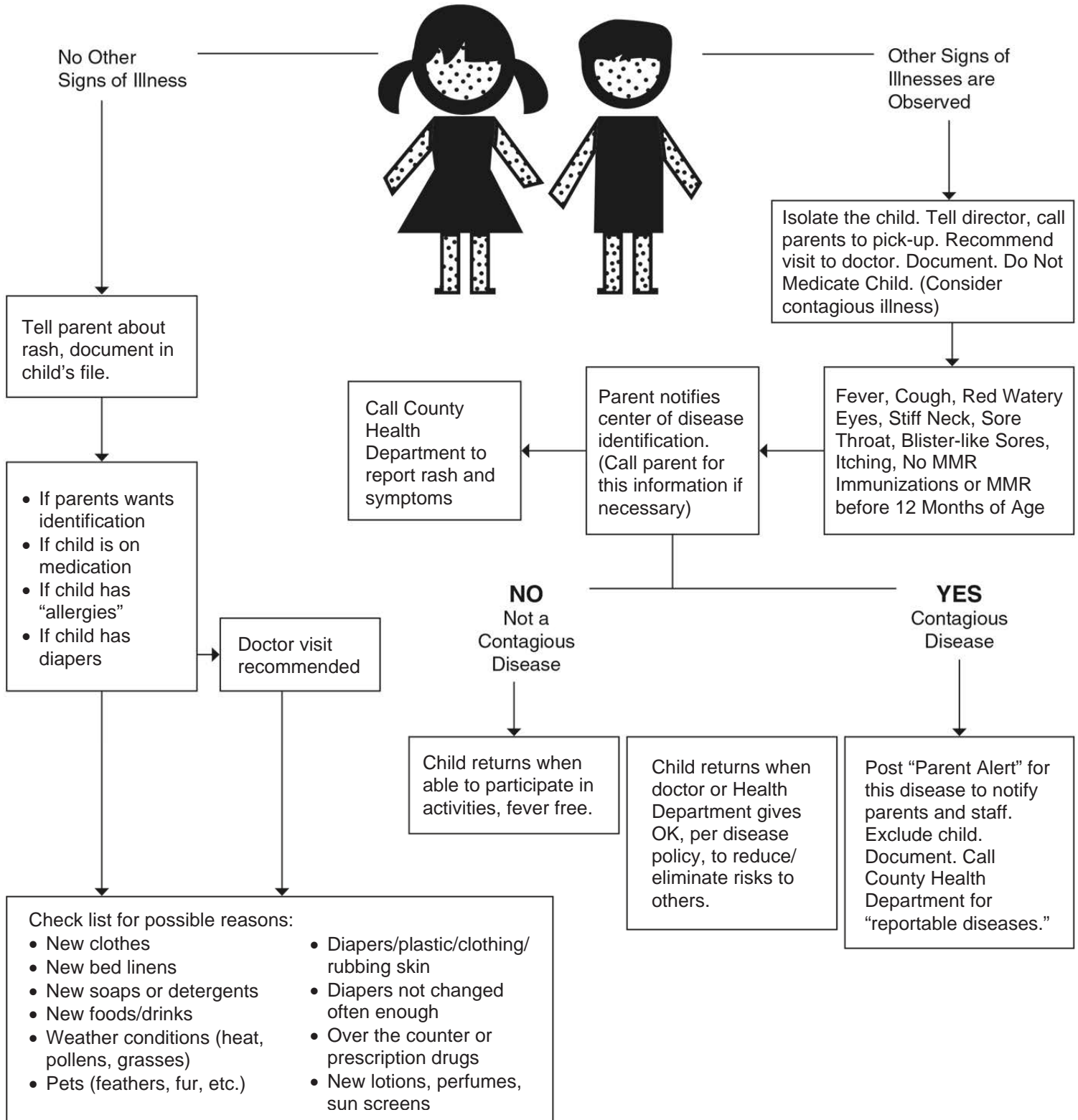
Children who are missing required shots must stay on the above "catch up" schedule to attend childcare. A 15-day notice must be given to parents whose children fall behind. If they do not provide proof of shots after 15 days, the child must be excluded from care until proof is given.

What **proof of immunization** is needed? Copies of shot records signed or stamped by the health care provider, and/or records from the Arizona State Immunization Information System (ASIIS) must be kept on file at the childcare facility.

***Important Note:** MMR and Varicella may be given on the same day. If they are not given on the same day, they must be separated by at least 28 days.

Arizona Department of Health Services, Immunization Program Office, www.azdhs.gov/phs/immun, 602-364-3630 or 866-222-2329

SECTION III—RASH FLOW CHART



SECTION III—FEATURES OF RASH ILLNESS/CONDITIONS

Pictures of many rash conditions can be accessed at: <http://hardinmd.lib.uiowa.edu/DERMPICTURES.HTML>

MEASLES (10 DAY OR HARD MEASLES)

SIGNS/SYMPTOMS:

3–4 days of fever higher than 101 F; red, watery eyes; sensitivity to light; cough; runny nose; fatigue

TYPE OF RASH:

Red, raised, blotchy rash which begins on face and neck; spreads downward covering the entire body; in 5-6 days rash is brownish color, occasional peeling appearance

OTHER FEATURES:

Highly contagious, airborne spread; white spots can appear in mouth, on inside of cheeks; rash does not usually itch*; immunization for prevention is important

RUBELLA (3 DAY OR GERMAN MEASLES)

SIGNS/SYMPTOMS:

Children may have few or no early signs; adults—1–5 days of low grade fever, headache, joint pains, runny nose, fatigue, red watery eyes, swollen glands in neck or behind ears

TYPE OF RASH:

Pink to red rash, beginning on head or neck and spreads downward, fades and disappears in about 3 days; no peeling appearance

OTHER FEATURES:

Many infections are so mild, they go unrecognized; serious concern to pregnant women; may cause birth defects in fetus*; immunization for prevention is important

CHICKENPOX (VARICELLA VIRUS)

SIGNS/SYMPTOMS:

Generally low grade fever for 1–3 days, loss of appetite, headache

TYPE OF RASH:

Early rash appears like insect bites, random sites, progresses to red, raised lesion with small watery blister in center; all stages of rash can appear at the same time; lesions usually crust and scab in 5–10 days

OTHER FEATURES:

Lesions can appear on scalp, genital regions, or in mouth, ears, or armpits; disease is spread by infected droplets in air or on surfaces and/or by contact with watery blisters

SECTION III—FEATURES OF RASH ILLNESS/CONDITIONS

SCARLET FEVER

SIGNS/SYMPTOMS:

1–3 days extremely tired, sore throat, fever, vomiting

TYPE OF RASH:

Fine, bright red rash that briefly turns white if you press on it; most prominent on neck, armpits, groin or folds of skin; light peeling of hands/feet; rough, sandpaper feel to the touch; spreads downward covering the entire body; in 5–6 days rash is brownish color, occasional peeling appearance

OTHER FEATURES:

Face can be flushed (red) with a white ring around the mouth; tongue can swell and look coated with red bumps

FIFTH'S DISEASE

SIGNS/SYMPTOMS:

Usually none, easily spread in epidemics among young children; may see low grade fever, fatigue, and body aches

TYPE OF RASH:

Red, brightly flushed cheeks, red lace-like rash on trunk, arms and legs; lasts about 7–9 days

OTHER FEATURES:

Sunlight makes rash worse; face has “slapped cheek” appearance; rash may fade/recur for few weeks; spread by respiratory secretions/airborne droplets

ROSEOLA

SIGNS/SYMPTOMS:

3–5 days of fever over 100 F, may see runny nose, fatigue and body aches

TYPE OF RASH:

Sudden, raised, smooth rash which disappears in 24–48 hours; starts on trunk, can become total body rash

OTHER FEATURES:

Rash follows the fever; generally mild illness, however it is easily spread in groups of young children

SECTION III—FEATURES OF RASH ILLNESS/CONDITIONS

HAND, FOOT & MOUTH (COXSACKIE VIRUS, ENTEROVIRUS)

SIGNS/SYMPTOMS:

Sudden onset, fever to 103 F; sore throat, cold-like symptoms, headache, fatigue, nausea, vomiting and diarrhea

TYPE OF RASH:

Red, raised rash, mostly on trunk and face; may appear on palms of hands/soles of feet; may see blisters in mouth, fluid-filled bumps on hands, feet; rash lasts 1–10 days

OTHER FEATURES:

Several different disease syndromes may be present; virus shed in stool, good handwashing is very important to limit spread of disease

IMPETIGO

SIGNS/SYMPTOMS:

Rash appears as little pin sized “pimples,” but evolves quickly into major skin eruptions filled with clear or cloudy colored pus

TYPE OF RASH:

Begins as small blisters that break, spreading discharge to skin surfaces; causes skin lesions; white or yellow crusty scabs form

OTHER FEATURES:

Children often have rash on chin, cheeks or mouth; Impetigo itches! Handwashing very important; medications needed for treatment

HEAT RASH (PRICKLY HEAT)

SIGNS/SYMPTOMS:

Often appears in moist skin folds of legs, arms and neck; also common at waistline and on buttocks

TYPE OF RASH:

Bands of reddened areas or patches of reddened skin surfaces

OTHER FEATURES:

Heat rash is a result of hot, humid conditions and direct skin contact with itself, wet diapers or clothing; most often associated with plastic diaper pants or disposable diaper plastic irritating the skin surface and increasing the sweat gland stimulus

SECTION III—FEATURES OF RASH ILLNESS/CONDITIONS

DIAPER RASH

SIGNS/SYMPTOMS:

Reddened skin on buttocks, or “diaper area” as a result of irritation from stool, urine, infection or prolonged contact with plastic diapering materials; grows in moist, warm conditions

TYPE OF RASH:

Rash can be generalized reddened skin surfaces, evolving to blistered appearance with skin breakdown; can become inflamed, moist and bleeding patches

OTHER FEATURES:

This rash causes discomfort and pain; diaper rash can be caused by prolonged contact with soiled diapers; this rash may be caused by fungal or viral infections which are contagious

DRUG OR FOOD REACTION RASHES

SIGNS/SYMPTOMS:

Ranges from fever, red runny eyes, hives, sores in the mouth, genital lesions, asthma like symptoms to extreme difficulty breathing

TYPE OF RASH:

Rash may appear as raised skin surfaces like “welts” or “hives” in a cluster; itching usually present; rash may appear rapidly, and can range from an isolated skin area to a full body rash

OTHER FEATURES:

Assess the use of new medications, foods or skin surface lotions, etc. to prevent further illness by immediately eliminating them; this rash can be a sign of a serious, quickly occurring condition, especially if it appears for no apparent reason or if other signs of illness are present

-
- If a rash occurs suddenly, with fainting, swelling, vomiting and/or difficulty breathing. **CALL 911**
 - Do not ignore rashes; they are not a normal state of health, and can be a symptom of contagious illness.
 - In group settings, post a “Parent Alert” notice if the rash is diagnosed or identified as a contagious condition.
 - Call the local health department for information regarding rash symptoms.
 - Even non-contagious rash conditions can be a symptom of a health threat, even if it is just unsightly, uncomfortable or itchy! Medical attention may be needed to reduce symptoms or disease risks.

SECTION III—ILLNESS PRECAUTIONS

STANDARD PRECAUTIONS

USE IN ALL SITUATIONS. ADD ADDITIONAL PRECAUTIONS AS RECOMMENDED.

- Wash hands before and after contact with the individual
- Wear gloves when touching blood, body fluids, secretions, and contaminated items or surfaces
- Keep items and linen that have been in contact with the individual from contaminating the environment
- Use care when handling sharps
- Discard disposable sharps into an impenetrable container
- Use a mouthpiece or other ventilation device (if available) when giving mouth-to-mouth resuscitation

DROPLET/AIRBORNE PRECAUTIONS *

Used to reduce the spread of diseases transmitted by droplets which travel through the air

Examples: influenza, chickenpox, strep throat, the common cold, and bioterrorism-related diseases such as smallpox and pneumonic plague

Use All Standard Precautions plus:

- Separate the individual from others. Provide care in an area where contact with others can be limited but the individual can be monitored. Avoid movement from room to room. If children are in cots or cribs next to one another, place them head to toe to increase the distance between faces.
- Provide tissues for containing coughs and sneezes. Instruct the individual to cover the mouth and nose when coughing or sneezing and discard used tissues in a plastic-lined trash can.
- Encourage frequent handwashing. If a handwashing sink is not available, provide disposable moistened towelettes to cleanse hands. An older child or adult may use an alcohol-based hand sanitizer.
- Use a facility-approved disinfecting solution, or bleach solution to sanitize the environment when the individual has been transferred or has gone home.
- Do not put masks on children. They can be frightening and are not needed.

CONTACT PRECAUTIONS

Used to reduce spread of diseases transmitted through skin-to-skin contact, or contact with contaminated objects or surfaces

Examples: rash illnesses, chickenpox, scabies, infected sores, and bioterrorism-related diseases such as smallpox or cutaneous anthrax

Use All Standard Precautions plus:

- Separate the individual and avoid movement from room to room.
- Cover sores to prevent direct contact
- Wear gloves when in contact with rashes or sores.
- Sanitize frequently-used items or frequently-touched surfaces at least daily.
- Use disposable items where possible.
- Limit use of equipment and supplies to a single individual when possible.
- Use an approved disinfecting product, or a bleach and water solution made with an EPA-registered bleach disinfectant made according to label instructions to sanitize the environment when the individual has been transferred or has gone home. Pay particular attention to sanitizing areas which have come into contact with sores or drainage from sores.

*While in hospitals and other acute care settings droplet and airborne precautions contain distinct elements, the steps which can be implemented in school or child care settings are the same for both categories.

PARENT ALERT LETTER

Dear Parent and/or Health Care Provider,

Date _____

_____ attends child care and is in _____ classroom.
(Child/staff full name) Age Group

Arizona Child Care Regulations require that child care programs NOT permit a child or staff to remain at the facility if the individual is showing signs of a communicable illness or infestation. A visit to a health care provider for diagnosis or recommendations for treatment may be needed.

A child may return when **fever-free for 24 hours without the aid of a fever-reducer** and/or when the symptoms have subsided and the threat of contagious disease spread is over, or when the local health department provides approval.

This illness has been diagnosed in the child care program attended by this child or adult:

(NAME OF ILLNESS)

Watch for these signs and symptoms:

- ☐ Fever (101 F by mouth or ear probe or 100 F under the arm)
- ☐ Rash
- ☐ Coughing
- ☐ Difficulty breathing
- ☐ Red, watery eyes
- ☐ Loose or watery stools (diarrhea)
- ☐ Dark urine
- ☐ Vomiting or complaints of "tummy ache"
- ☐ Pulling at the ears
- ☐ Very tired
- ☐ Other _____

If these signs or symptoms are observed DO NOT bring a child for care or report for duty. Contact the child care program to report the illness. If seeing a medical provider, take this letter with you.

If a Health Provider visit is made, please complete this information

DIAGNOSIS _____ DATE OF VISIT _____

MEDICATIONS? Yes No

RECOMMENDATIONS? _____

SECTION III—PREPAREDNESS & BIOTERRORISM EVENTS

Natural and manmade emergencies can happen at any time. Even a widespread outbreak of a disease like influenza may test the policies and procedures for exclusion, emergency communications, and care of symptomatic individuals put into place by schools and other children's group settings.

Every program which has responsibility for the care of young children should develop written policies and procedures which are shared with staff and families. Families should also be encouraged to develop their own emergency plans and the program may want to take advantage of literature offered by the websites below.



ADDITIONAL INFORMATION:

(Links below were deemed reliable information at the time of publication)

CDC Emergency Preparedness and Response: <http://www.bt.cdc.gov/>

Sesame Street: Let's Get Ready! <http://www.sesamestreet.org/parents/topicsandactivities/toolkits/ready>

Arizona Department of Health Services Bureau of Child Care Licensing Emergency Preparedness in Childcare Settings: <http://www.azdhs.gov/als/childcare/preparedness/childcare.htm>

Just in Case Arizona from the Arizona Emergency Information Network: <http://www.justincasearizona.com/>

HOW TO DEAL WITH POSSIBLE EVENTS

DISEASE OR BIOTERRORISM | EXPOSURES SUSPICIOUS MAIL OR PACKAGES | TELEPHONE THREATS

WHAT TO DO AT THE TIME OF A POSSIBLE EXPOSURE TO A DANGEROUS INFECTIOUS DISEASE OR A BIOLOGICAL AGENT

- Notify authorities, building security, and your supervisor
- Follow your established Emergency Plan
- Make a list of all the people who were in the room at the time of exposure

POWDER ON A SURFACE (STAY IN ROOM/ AREA UNTIL NOTIFIED TO DO OTHERWISE. DON'T EXPOSE OTHERS)

- Do not touch or clean up spilled powder (The authorities may want to collect it as evidence)
- Gently cover powder with damp paper, clothing, trash can, etc. Do not remove this cover
- Close the door to prevent others from entering the room
- Move everyone to the opposite end of the room and sit quietly (read, tell stories, etc.)
- Do not touch your eyes, nose or open sores
- Wash your hands and contaminated skin with soap and water (or waterless hand antiseptic if soap and water are not available) as soon as possible. (You may also request someone to bring these to your door for you)
- If appropriate, seal contaminated clothing into a plastic bag. Save for authorities

SECTION III—PREPAREDNESS & BIOTERRORISM EVENTS

SUSPICIOUS POWDER OR SPRAY OR MISTS FLOATING IN THE AIR (ASSESS THE SITUATION FOLLOW YOUR EMERGENCY PLAN)

- If the outdoors seems to be filled with powder/mists... then stay in room, turn off fans, air conditioners, heaters, exhaust fans, etc.
- If your room appears to be the only area affected with floating powder, mist, spray, etc.... then evacuate the room and move to a safer location.

SUSPICIOUS SORES

- Cover with a bandage or appropriate covering. Wash hands. Refer for medical evaluation

NEUROLOGICAL SYMPTOMS (FACIAL WEAKNESS, DOUBLE VISION, SIGNIFICANT MUSCLE WEAKNESS)

- Call 911.
- Provide first aid and supportive care

WHAT TO DO WHEN MAIL OR PACKAGES ARE SUSPECTED TO CONTAIN DANGEROUS GERMS

- May have no return address, no postage, non-canceled postage, incorrect spelling of common names. May be lopsided, rigid, bulky, stained, discolored or have threatening messages
- **Do not shake, open or empty the envelope or package**

HOW TO HANDLE TELEPHONE THREATS

Implement your program or facility's existing emergency plan

- Don't hang up! (Student office workers should give the call to an adult ASAP)
- Write down the time and exact wording of the threat
- Ask what type of threat is planned (bomb, fire, physical violence, kidnapping, biological)
- Who is the caller and why is he making the threat? Against whom is the threat directed?
- When will the threat happen?
- Is the caller male or female? Is the voice familiar? Are there noises in the background?
- If a bomb, where is it, what does it look like and what will cause it to explode?
- **Call police (911) if threatening or suspicious individuals are present**

Developed by Pima County Health Dept (School Bioterrorism Infection Control Committee) Tucson, AZ.
Please attribute source.

SECTION IV

SECTION IV—GLOSSARY

ANTIBIOTIC

Chemical substances which kill or slow the growth of specific germs. Antibiotic treatment may be in the form of pills, capsules, ointments, creams, liquids, injections, or intravenous therapy.

BODY FLUIDS

Urine, feces (stool), saliva, blood, nasal discharge, eye discharge, semen, vaginal secretions, breast milk, and discharge from sores or injuries.

CARRIER

An individual who may not have disease signs or symptoms but may still be infected and capable of passing infectious germs to others.

CASE

An individual with signs and/or symptoms of a disease, and whose disease is diagnosed by a doctor or laboratory tests.

CASE REPORTS

Written reports of diagnosed illness, completed on the standard Arizona Communicable Disease Report form and mailed promptly to the local health department. Some serious or highly contagious illnesses must be reported immediately (by telephone). See the specific disease information. Case Report forms are available from the local health department and on the internet at http://www.azdhs.gov/phs/oids/pdf/forms/cdr_form.pdf

CASUAL CONTACT

Association with an individual which does not involve sexual activity, sharing of needles for injecting drugs, or sharing personal items such as toothbrushes, razors or nail clippers.

CONTACT

An individual who has been in association with an infected person, animal, or place in such a way as to have an opportunity to “catch” or pass on the infection.

CONTAGIOUS PERIOD

The period of time when an infected person can spread the infection to another individual.

DIARRHEA

An increased number stools, or abnormally loose, or unformed watery stools, in comparison to an individual’s usual bowel habits.

EPIGLOTTITIS

Swelling and inflammation of the “lid” of the voice-box. This swelling can block breathing passages.

ERYTHROMYCIN

An antibiotic used to treat many kinds of infection.

SECTION IV—GLOSSARY**FEVER**

An elevation of body temperature, above 101°F taken by mouth, 100°F taken under the arm, or above 102°F taken rectally (rectal temperatures should be taken only by individuals trained to do this). An individual with fever associated with behavior change or another sign/symptom of communicable disease should be excluded from the group setting. Unless prolonged or very high fevers are not considered harmful in typical healthy children.

FEVER-FREE

Without fever for 24 hours without the use of fever-reducing agents such as aspirin, acetaminophen, or ibuprofen.

FONTANELLE

The “soft spot” on the top of a baby’s head.

FOOD HANDLER

An individual who prepares, transports, or serves food. Also an individual who comes in contact with food service utensils or equipment.

FUNGUS

Plant-like organisms, such as yeast, mold, and mildew.

HOUSEHOLD CONTACT

Individuals who share a home or living situation such as a shelter or dormitory.

IMMEDIATE INTERVENTION

Actions to be taken upon suspicion that a specific disease or condition exists to improve the individual’s health and prevent spread.

IMMEDIATE MEDICAL ATTENTION

Prompt examination (within a few hours) by a health care provider, in an office, clinic, urgent care or emergency setting.

IMMUNITY

Ability of an individual’s body to resist a particular infection. This ability may be present because the individual has already had the infection, or the individual may have received vaccine to help resist infection.

IMMUNE GLOBULIN

An antibody preparation made from human blood. These preparations provide temporary immunity against specific infections.

IMMUNIZATION

Vaccines given to individuals to help them develop protection (antibodies) against specific infections.

IMMUNOCOMPROMISED

An individual who does not have the normal body defenses to fight off infections. Examples can include those who are HIV-positive, on chemotherapy or receiving long-term steroid therapy.

SECTION IV—GLOSSARY

INCUBATION PERIOD

The time between exposure to infectious germs and the beginning of disease symptoms.

INFECTIOUS

Capable of causing an infection or disease.

INFESTATION

Having parasites (such as lice or scabies) living on the outside of the body.

JAUNDICE

Yellowing of the whites of the eyes and/or skin.

LISTLESSNESS

Feeling tired or without energy.

NAUSEA

Feeling sick to one's stomach, or as if one will vomit.

OSHA

An abbreviation for the Occupational Safety and Health Administration of the U.S. Department of Labor, which administers the Occupational Safety and Health Act, regarding health and safety in the work place.

OUTBREAK

A sudden rise in the frequency of disease over what is usually seen or expected. For a disease such as measles, ONE case would be an outbreak. A general rule of thumb might be 10% of individuals in the group setting (or 3 individuals in the same classroom) with similar signs or the same diagnosis. Guidance on the definition of an outbreak can change with current disease patterns. Check with the state or local health department.

PROTOZOAN

Very small, one-celled animals, some of which may cause disease.

REYE'S SYNDROME

A rare, but very serious disease which may follow viral infections. Symptoms include nausea and vomiting, confusion, and coma. The use of aspirin products during viral illnesses such as chickenpox and influenza has been associated with Reye's syndrome.

RIFAMPIN

An antibiotic often prescribed for those who have been exposed to an infection caused by *Haemophilus influenzae* type b, or meningococcal meningitis. Also used in multi-drug treatment of tuberculosis.

SECRECTIONS

Wet material or fluid, such as saliva, that is produced by the body and has a specific purpose in the body.

SECTION IV—GLOSSARY**SHINGLES**

A recurrence of a previous infection with varicella virus. It is seen mostly in adults. Small blisters along the path of a nerve (frequently about the waist), accompanied by pain, may be shingles. The fluid in these blisters may cause chickenpox in individuals who have never had chickenpox.

SIGN

Evidence of disease that can be seen or measured by another individual (such as a rash or fever).

SPUTUM

Secretions produced by the lungs, trachea (windpipe), and other air passages.

SUSCEPTIBLE

An individual who is not immune to a specific disease.

SUSPECT CASE

An individual whose signs and/or symptoms suggest he may have or be developing a communicable disease.

SUSPECT CARRIER

An individual who may be infected and capable of passing infectious germs to others without having signs or symptoms of the disease itself.

SYMPTOM

Evidence of disease felt by an individual (such as nausea).

TRANSMISSION

The passing of infectious germs or parasites from one individual to a susceptible individual, from animals to an individual or from the environment to an individual.

VACCINES

Preparations which contain killed or weakened organisms, given to assist the body in developing immunity (antibodies) to specific diseases.