VDH VIRGINIA DEPARTMENT OF HEALTH

Communicable Disease Reference Chart for School and Childcare Facility Personnel*

Disease	Incubation period	Transmission	Common symptoms	Recommendations
Chickenpox† (Varicella)	14–16 days (Range 10–21 days) Incubation period may be longer (28 days or more) in persons who receive immune globulin for postexposure prophylaxis (VariZIG or IVIG). Incubation period may be shorter in persons with weakened immune systems.	Direct contact with vesicular fluid or by airborne spread from respiratory tract secretions. Infectious from 2 days before rash onset until all lesions have dried/crusted over and no new lesions appear within a 24-hour period (average is 4–7 days). Communicability may be prolonged in people with weakened immune systems.	Sudden onset with slight fever, other systemic symptoms and itchy eruptions which become vesicular (small blisters) within a few hours. The rash first appears on the chest, back, and face, and then spreads over the entire body. Lesions commonly occur in successive crops, with several stages of maturity present at the same time. Typically, vesicular rash consisting of 250–500 lesions in varying stages of development (papules, vesicles) and resolution (crusting).	**PATIENT:** Exclude from school or childcare setting until: • Uncomplicated varicella regardless of vaccine status: the rash has crusted • Immunized patients without crust: no new lesions appear within a 24-hour period • Patients with weakened immune systems: at least 5 days after eruptions first appear and until vesicles become dry Avoid exposure to pregnant women who have not had chickenpox and/or varicella vaccine. **CONTACTS:** Check vaccination status of contacts in school and childcare setting. Recommend vaccination within 3 days and up to 5 days after exposure for postexposure prophylaxis if person is not immune. Even if it has been more than 5 days, the vaccine should still be offered to protect against future exposures. For exposed contacts without immunity: • School setting: exclusion not recommended unless an outbreak (three or more epi-linked cases within 21 days in group or facility) is reported; monitor for varicella symptoms for 8–21 days from exposure and until 28 days after for those who received VariZIG or IVIG. • Childcare setting: exclusion recommended for 8–21 days from exposure (28 days if VariZIG or IVIG given.) • If symptoms occur, exclude from school and childcare setting.

Communicable Disease Reference Chart for School and Childcare Facility Personnel*

Disease	Incubation period	Transmission	Common symptoms	Recommendations
Conjunctivitis (Pink Eye)	1–3 days Variable depending on the cause. Causes include bacteria, viruses, allergies, and chemicals/irritants.	Contact with eye discharge or contaminated articles, if the cause is infectious (e.g., bacteria or virus.) Allergic and chemical causes are not contagious.	Pink or red eye with swelling of the eyelids, increased tears, and eye discharge. Eyelids may be matted shut after sleep. May involve one or both eyes.	**PATIENT:** For viral or bacterial conjunctivitis, exclude from school or childcare setting while symptomatic or until cleared to return by a healthcare provider. It is important to wash hands thoroughly after contact with eye drainage. Do not share any articles that have come into contact with the eyes. **CONTACTS:** Exclusion not indicated.
COVID-19† (Coronavirus disease 2019 caused by SARS-CoV-2 virus) Suspected or confirmed COVID-19 cases are no longer required to be reported (except by laboratories). Reporting of suspected outbreaks or clusters is still required.	2–14 days As virus variants continue to emerge, characteristics such as incubation period and ease of transmission may change.	Inhalation or contact with respiratory droplets; contact with contaminated surfaces. People are infectious 2 days before symptom onset through 10 days after symptom onset, with viral loads higher earlier in the course of infection.	Patients may be asymptomatic or may have a wide variety of symptoms of variable severity: • Fever and/or chills • Cough and/or runny nose • Shortness of breath • Headache • Fatigue • Sore throat • Muscle or body aches • New loss of taste or smell • Nausea, vomiting, diarrhea	**PATIENT:** Please refer to CDC's "Preventing Spread of Respiratory Viruses When You're Sick." In general, people can return to normal activities when symptoms are getting better overall AND they have not had a fever for at least 24 hours (and are not using fever-reducing medication). Depending on severity of illness, refer to a healthcare provider, urgent care center, or emergency department for further evaluation and treatment. **CONTACTS:** Exclusion is not recommended for contacts.
Diarrheal Diseases† (Campylobacteriosis, Infection with Shiga toxin-producing *E. coli* (STEC), including *E. coli* O157:H7, Giardiasis,	Campylobacteriosis: 2–5 days (Range: 1–10 days) *E. coli* O157:H7: 3–4 days (Range: 1–10 days)	Fecal-oral route through direct contact or by ingestion of contaminated, raw, or improperly cooked food or untreated water	The most common symptoms are diarrhea, abdominal pain or cramping, malaise, and fever. Stools can contain visible or occult blood. Severe dehydration may occur in young children.	**PATIENT:** Exclude from school and childcare setting until diarrhea has ceased for at least 24 hours. Stools should be contained in the diaper or when continent patients no longer have fecal accidents and when stool frequency becomes no more than 2 stools above normal frequency for the patient, even if the stools remain loose. Stress the importance of proper handwashing. In an outbreak setting, consult local health department for clearance to return to

Disease	Incubation period	Transmission	Common symptoms	Recommendations
Salmonellosis, Shigellosis, etc.)	Giardiasis: 1–3 weeks Salmonellosis: 12–36 hours (Range: 6–72 hours; though up to 16 days has been reported) Shigellosis: 1–3 days (Range: 1–7 days)		Campylobacteriosis may mimic appendicitis or intussusception. *E. coli* O157:H7 may lead to hemolytic-uremic syndrome. In giardiasis, persons may be asymptomatic or have malabsorption with smelly, greasy stool and weight loss. Patients with weakened immune systems can have prolonged, relapsing, or extraintestinal infections.	school/childcare setting. • **Childcare** setting: For STEC, exclude until two negative stool specimens, collected at least 24 hours apart, and not earlier than 48 hours after discontinuing antibiotics (if administered). **CONTACTS:** Exclusion and stool cultures not indicated in absence of symptoms. Contacts who are symptomatic should be excluded until diarrhea has ceased for at least 24 hours. Stools should be contained in the diaper or child is continent and stool frequency is no more than 2 stools above that child's normal frequency for the time the child is in the program. Collection of stool specimens are recommended for symptomatic contacts, and these children should be excluded from school and childcare setting while evaluation is pending. Consult with your local health department for advice during suspected school outbreaks. Thorough hand hygiene and environmental cleaning are important.
Fifth Disease (Parvovirus B19, Erythema Infectiosum)	4–14 days (Range: 4–21 days)	Contact with respiratory tract secretions and percutaneous exposure to blood or blood products. It can also be transmitted from mother to baby during pregnancy. Once the characteristic rash appears, the child is not likely to be contagious and can return to school.	Distinctive rash characterized by a vivid reddening of the skin, especially of the face, which fades and recurs; classically, described as a “slapped cheek appearance.” The rash may have a lacey appearance on the trunk and extremities. It can fluctuate in intensity and recur with environmental changes, such as temperature and exposure to sunlight, for weeks to months. Mild symptoms of fever, joint pain, cough, sore throat, and headache may occur 7–10 days before rash.	**PATIENT:** Exclusion not indicated beyond facility-based policies about fever or rash. **CONTACTS:** Exclusion not indicated. Pregnant women and persons with weakened immune systems should seek medical advice.

Communicable Disease Reference Chart for School and Childcare Facility Personnel*

Disease	Incubation period	Transmission	Common symptoms	Recommendations
Hand, Foot, and Mouth Disease (Coxsackievirus, Enterovirus)	3–5 days	Contact with nose and throat secretions, fluid from blisters, or stool from an infected person. Can also spread by contact with contaminated articles or surfaces. People are most contagious during the first week of illness but can spread virus for days or weeks after symptoms go away. People who are infected can spread virus even if they never had symptoms.	Initial symptoms include fever, poor appetite, malaise, and sore throat. Mouth sores and rash may develop 1–2 days later. Rash appears flat or slightly raised red spots, sometimes with blisters. Rash is commonly on palms of hands and soles of feet but can affect other areas (e.g., knees, elbows, or buttocks). Symptoms typically last 7–10 days. Skin lesions heal within 3–5 days after illness onset.	**PATIENT:** Exclude from school or childcare setting for at least 24 hours after fever is gone without use of fever-reducing medicine and there is not uncontrolled drooling with mouth sores. Parents/guardians are encouraged to talk to their healthcare provider about when to return to school or childcare setting if the rash is still present and there are blisters in the mouth and excessive drooling. **CONTACTS:** Exclusion not indicated. Thorough hand hygiene and environmental cleaning are very important.
Hepatitis A† **All suspected or confirmed cases are rapidly reportable to the local health department**	28 days (Range: 15–50 days)	Fecal-oral route through direct contact or ingestion of contaminated food or water. People with Hepatitis A virus (HAV) infection are most infectious during the 1–2 weeks before illness onset, when concentration of virus in the stool is highest. Risk diminishes significantly by 7–10 days after symptom onset and is minimal by the 3rd week of illness.	Initial symptoms begin abruptly and include fever, nausea, vomiting, diarrhea, fatigue, joint pain, anorexia, and abdominal pain or discomfort. Dark urine, pale stools, and jaundice (yellowing of the skin or eyes) might be present initially or might develop a few days to a week later. The likelihood of symptoms increases with age. Symptoms typically last less than 2 months but can extend up to 6 months.	**PATIENT:** Patients with acute HAV infection who work as food handlers or attend or work in childcare settings should be excluded for 14 days if symptomatic, or 7 days since jaundice. If the person is not a food handler or in a childcare setting, exclude for 7 days after onset of symptoms. Serologic testing should be performed to confirm HAV infection in suspected cases. **CONTACTS:** Determine if contact is immune to HAV through immunization records and/or serologic testing (a positive Hep A IgG). Serologic testing is not typically recommended if immunization records are unavailable. It could be considered in specific settings to reduce costs by not vaccinating people who are already immune. Contacts who are immune do not need additional follow-up. Determine if contact meets criteria for HAV postexposure prophylaxis (PEP) with Hepatitis A vaccine, immunoglobulin, or both. Childcare staff or attendees who might have been exposed to HAV in the past 2 weeks should be excluded for 7 weeks after last contact with the case during the infectious period, unless they receive PEP within 14 days

Disease	Incubation period	Transmission	Common symptoms	Recommendations
				of exposure or report immunity through vaccination or serology indicating previous disease. Contacts who are symptomatic and epidemiologically-linked to a laboratory-confirmed case meet the case definition and should be managed as a case, including appropriate investigation and exclusion. In a childcare setting, stress the importance of proper handwashing. In facilities with diapered children, if one or more cases are confirmed in child or staff attendees or two or more cases in households of staff or attendees, hepatitis A PEP should be administered within 14 days of exposure to all unimmunized staff and attendees. In centers without diapered children, hepatitis A PEP should be administered only to unimmunized classroom contacts of index case. Asymptomatic contacts may return after receipt of hepatitis A PEP. If questions about management of cases and/or contacts, please contact the local health department.
Hepatitis B†	60–90 days (Range: 45–160 days)	Direct contact with infected blood or other body fluids. Transmission occurs when the hepatitis B virus (HBV) enters the body through breaks in the skin or through mucous membranes. The risks of HBV acquisition when a susceptible child bites a child with chronic HBV infection, or when a susceptible child is bitten by a child with chronic HBV infection, is unknown. Although there is a theoretical risk	Developing symptoms of acute hepatitis are age-dependent and occur most commonly in adults. Up to half of all older children, adolescents, and adult experience symptoms. However, most children younger than five have no symptoms. The spectrum of symptoms and signs is varied and includes subacute illness with nonspecific symptoms (e.g., anorexia, nausea, or malaise), clinical hepatitis with jaundice, or fulminant hepatitis.	**PATIENT:** Follow advice of child's healthcare provider and/or your local health department. **CONTACTS:** Exclusion not indicated.

Disease	Incubation period	Transmission	Common symptoms	Recommendations
		if HBsAg-positive blood enters the biter's mouth, transmission through this route has not been documented.		
HIV Infection† and AIDS† (Acquired Immunodeficiency Syndrome)	For untreated infants and children who acquire HIV infection through mother-to-child transmission, the usual age of onset of symptoms is 12–18 months of age. Some children become ill in the first few months of life, but others remain asymptomatic for more than 5 years and, rarely, until early adolescence. Acute retroviral syndrome develops in 40–90% of adults and adolescents. It occurs 7–14 days following viral acquisition and lasts 5–7 days. Most patients are not ill enough to seek medical attention.	1. Sexual transmission (vaginal, anal, orogenital) 2. Percutaneous blood exposure (e.g., contaminated needles) 3. Mother-to-child transmission 4. Mucous membrane exposure to contaminated blood or body fluids 5. Transfusion of contaminated blood or blood products, though this has been virtually eliminated in the U.S. since 1985 6. Cases of HIV transmission have been reported from contact of non-intact skin with blood-containing body fluids	Clinical manifestations of untreated pediatric HIV infection include unexplained fevers, generalized lymphadenopathy, hepatomegaly, splenomegaly, failure to thrive, persistent oral and diaper candidiasis, recurrent diarrhea, parotitis, hepatitis, central nervous system disease (e.g., encephalopathy, hyperreflexia, hypertonia, floppiness, developmental delay), lymphoid interstitial pneumonia, recurrent invasive bacterial infections, and opportunistic infections (e.g., viral, parasitic, and fungal infections).	**PATIENT:** Follow advice of child's healthcare provider and/or your local health department. **CONTACTS:** Exclusion not indicated.
Influenza (Seasonal) Note: Suspected or confirmed novel influenza virus infections should be rapidly reported to the local health department and may have different	2 days (Range: 1–4 days)	Respiratory droplets (e.g., coughing or sneezing), contaminated hands or surfaces (where it can remain for up to 24 hours), or airborne transmission via small-particle aerosols in the vicinity of the infectious individual	Sudden onset of fever, often accompanied by nonproductive cough, chills or rigors, diffuse myalgia, headache, and malaise. Subsequently, respiratory tract symptoms, including sore throat, nasal congestion, rhinitis, and cough, become more prominent. Less commonly,	**PATIENT:** Exclude from school and childcare setting until symptoms are getting better overall AND they have not had a fever for at least 24 hours (and are not using fever-reducing medication). **CONTACTS:** Exclusion not indicated.

Disease	Incubation period	Transmission	Common symptoms	Recommendations
exclusion criteria.		Patients may be infectious 24 hours before onset of symptoms. Viral shedding in nasal secretions usually peaks during the first 3 days of illness and ceases within 7 days but can be prolonged (10 days or longer) in young children and people with weakened immune systems.	abdominal pain, nausea, vomiting, and diarrhea are associated with influenza. In some children, influenza can appear as an upper respiratory tract illness or as a febrile illness with few respiratory tract symptoms. In infants, influenza can produce a nonspecific sepsis-like illness picture, and in infants and young children, influenza can cause otitis media, croup, pertussis like-illness, bronchiolitis, or pneumonia. Acute myositis secondary to influenza can present with calf tenderness and refusal to walk.	
Measles† (Rubeola, Red Measles) **All suspected or confirmed cases are rapidly reportable to the local health department**	From exposure to prodrome: 11–12 days (average) From exposure to rash onset: 14 days (Range: 7–21 days)	Direct contact with infectious droplets or by airborne spread through inhalation of infectious droplets when a person with measles coughs, sneezes, etc. The attack rate in a susceptible individual exposed to measles is 90% in close-contact settings. Patients infected with wild-type measles virus are contagious from 4 days before rash onset through 4 days after appearance of the rash.	Fever, cough, coryza, and conjunctivitis, followed by a maculopapular rash starting on the face and spreading downwards and outwards. During the initial period, Koplik spots may be present. The characteristic rash may not develop in patients with weakened immune systems. Koplik spots are typically 1-3mm whitish, grayish, or bluish elevations with an erythematous base typically seen on the buccal mucosa. Koplik spots are not seen in all measles cases.	**PATIENT:** Exclude from school and childcare setting until at least 4 days after appearance of the rash and when the child is able to participate. **CONTACTS:** Check immunization records of all contacts. Additional measures are not needed for children and/or staff who are fully vaccinated or have evidence of immunity to measles. Non-immune persons, including those exempted from measles immunization for medical reasons, should be excluded from school, childcare setting, and healthcare settings. Duration of restriction depends on health status (e.g., pregnancy), timing and type of postexposure prophylaxis (vaccine or immune globulin), if given. Discuss with your local health department and refer to VDH's guidance. Every suspected measles case should be reported immediately to the local health department.

Communicable Disease Reference Chart for School and Childcare Facility Personnel*

Disease	Incubation period	Transmission	Common symptoms	Recommendations
Meningitis, Bacterial (H. influenzae†, Meningococcal†, Pneumococcal) **All suspected or confirmed cases of invasive *H. influenzae* disease or meningococcal disease are rapidly reportable to the local health department**	*H. influenzae*: Undefined Meningococcal: 1–10 days Pneumococcal: Unknown and varies by type of infection (may be as short as 1 to 3 days).	Respiratory (e.g., coughing or sneezing) or throat secretions (e.g., kissing) through close or lengthy contact. Transmission can also occur by sharing beverages, utensils, tobacco products, and personal care products. Patients should be considered capable of transmitting the organism for up to 24 hours after initiation of effective antimicrobial treatment.	Acute onset of fever, neck stiffness, neck pain, headache, light sensitivity and other neurologic symptoms or signs. Patients with septicemia may develop fever, diarrhea, nausea, vomiting, and muscle aches. In meningococcal disease, rash initially can be macular or maculopapular but typically becomes petechial or purpuric within hours. Signs and symptoms of meningococcal meningitis may be indistinguishable from those associated with pneumococcal meningitis.	**PATIENT:** Exclude from school and childcare setting during acute illness. Non-communicable after 24–48 hours of appropriate drug therapy. **CONTACTS:** Exclusion not indicated. Discuss with your local health department to determine if close contacts need **prompt prophylactic treatment** for *H. influenzae* or meningococcal disease, especially contacts in a childcare setting. Students and staff should be advised not to share beverages, eating utensils, or personal care products. Infants and young children should not share bottles, toys, or other items placed in the mouth.
Mononucleosis (Mono, Epstein-Barr Virus)	4–6 weeks	Person-to-person spread through bodily fluids, especially saliva (kissing or sharing objects contaminated with saliva). EBV is the most common cause of mononucleosis but can be caused by other viruses.	Extreme fatigue, fever, sore throat, headache, body aches, swollen lymph nodes in neck and armpits, swollen liver or spleen. Rash may be present. Young children may have mild or no symptoms. Most people feel better in 2 to 4 weeks. Some people feel fatigued for several more weeks or rarely, months.	**PATIENT:** Exclusion not indicated. Avoid activities that cause saliva exchange (e.g., sharing glasses or utensils). Patient should avoid strenuous physical exercise and contact sports for at least a month or until the spleen is no longer palpable. Parents/guardians are encouraged to talk to their healthcare provider about resuming sports. **CONTACTS:** Exclusion not indicated.
Mpox† (Previously known as monkeypox) **All suspected or confirmed cases are rapidly reportable to the local health department**	3–17 days Symptoms usually start within 21 days of exposure to the virus. If someone has flu-like symptoms, they will usually develop a rash 1–4 days later.	Through close contact (including intimate, sexual, or household/caregiving contact) with a person with mpox (e.g., skin-to-skin, body fluids, prolonged talking or breathing, from mother to baby), and through contact with contaminated materials	People with mpox get a rash that may be located on the hands, feet, chest, face, in or around the mouth, or on or around the genitals or anus. The rash will go through several stages, including scabs, before healing. The rash can initially look like pimples or blisters and may	**PATIENT:** Exclude from school and childcare setting until the rash has healed, all scabs have fallen off, and a fresh layer of skin has formed. This may take as long as 4 weeks after symptoms began. Caregivers should work with a healthcare provider and the health department to decide when the child or adolescent can return to the educational setting. **CONTACTS:** Exclusion not indicated in most

Disease	Incubation period	Transmission	Common symptoms	Recommendations
		(e.g., clothing, bedding), or direct contact with infected wild animals. Mpox can be spread from the time symptoms start until the rash has fully healed and a fresh layer of skin has formed. The illness typically lasts 2–4 weeks.	be painful or itchy. Other symptoms of mpox can include fever, chills, swollen lymph nodes, exhaustion, muscle aches and backache, headache, and respiratory symptoms (e.g., sore throat, nasal congestion, or cough). People may have all or only a few symptoms.	cases. In some cases, if contact tracing may not be possible and there was a high or intermediate degree of exposure, the local health department may consider limiting an individual's participation in activities. The health department will consider the age of the individual and their ability to recognize or communicate symptoms, the types of interactions in the environment, and the risk of more severe disease to others in the setting. If a contact had high- or intermediate-risk exposure, the health department may recommend postexposure prophylaxis with JYNNEOS vaccine, ideally administered within 4 days of exposure. Settings with children or adolescents in residence, (e.g., boarding schools, overnight camps, and other residential environments) follow considerations for congregate settings.
Mumps†	16–18 days (Range: 12–25 days)	Contact with infectious respiratory tract secretions and saliva. Highly contagious. The period of maximum communicability begins 2 days before parotitis onset. The recommended isolation period is 5 days after onset of parotid swelling. However, virus has been detected in patients' saliva as early as 7 days before and until 9 days after onset of swelling.	Swelling and tenderness of one or both parotid glands as well as nonspecific symptoms such as fever, muscle aches, loss of appetite, malaise, and headache. Asymptomatic infection occurs in about 15-20% of cases, usually in adults more than children.	**PATIENT:** In addition to standard precautions, exclude from school and childcare setting for 5 days after the onset of parotid gland swelling. **CONTACTS:** Determination of vaccination status should be obtained for all contacts. In an outbreak setting, consult local health department regarding outbreak management and whether contacts need to be excluded from school or childcare setting. If health department agrees, unimmunized contacts should be excluded until at least 26 days after onset of parotitis in the last person with mumps. Excluded students can be readmitted after receipt of a dose of MMR vaccine at the discretion of the health department. Moreover, if people at the school or childcare setting are considered to be at high risk for mumps, a recommendation may be made for students and staff who have had two doses of a mumps-containing vaccine to receive

Communicable Disease Reference Chart for School and Childcare Facility Personnel*

Disease	Incubation period	Transmission	Common symptoms	Recommendations
				a third dose of MMR vaccine.
Norovirus	12–48 hours	Fecal-oral or vomitus-oral route through direct contact, ingestion of contaminated food or water, touching contaminated surfaces, and aerosolized vomitus. Viral shedding may start before onset of symptoms, peaks several days after exposure, and in some cases, may persist for ≥4 weeks. Prolonged shedding (>6 months) has been reported in people with weakened immune systems.	Sudden onset vomiting and/or watery diarrhea, abdominal cramps, and nausea. Symptoms typically last from 24–72 hours, but prolonged illness can occur. Systemic manifestations, including fever, myalgia, malaise, anorexia, and headache, may accompany gastrointestinal tract symptoms.	**PATIENT:** In addition to standard precautions, exclude people with suspected or confirmed norovirus from school and childcare setting until 48 hours after symptoms resolve. This includes resolution of vomiting and diarrhea. Infants and children should be excluded from childcare settings until stools are contained in the diaper or when toilet-trained children no longer have accidents using the toilet and when stool frequency becomes no more than 2 stools above that child's normal frequency for the time the child is in the program, even if the stools remain loose. Stress importance of thorough handwashing with soap and water, especially when caring for diapered children, as virus may be shed in stool for weeks after symptoms resolve. **CONTACTS:** Exclusion not indicated. If symptoms occur in contacts, restrict from school and childcare setting as above. Can restrict based on symptoms without diagnosis from provider. Environmental cleaning is a very important component of the response to a norovirus outbreak. A high-concentration bleach solution can be used—this solution must remain on the surface for enough time to kill norovirus. Surface must be rinsed with water to remove bleach residue.
Pediculosis (Head Lice)	8–9 days for eggs to hatch after being laid (Range 7–12 days) Lice mature into adults about 7 days later.	Direct head-to-head contact with hair of an infected person. Transmission by contact with personal belongings (e.g., combs, brushes, sporting gear, hats) is uncommon. Head lice infestation occurs most commonly in children attending childcare, preschool,	Severe itching and scratching. Adults, eggs, and nits (empty egg casings) are found on the hair, often seen behind ears and at the nape of the neck. Excoriations and crusting caused by secondary bacterial infection may occur. Many children are	**PATIENT:** Notify parents; inform that child has lice and should be treated. Children should not be excluded or sent home early from school or childcare setting because of head lice because head lice have a low contagion within classrooms. "No-nit" policies should be discouraged. **CONTACTS:** Household and close contacts should be examined and treated if infested. If the individual with lice shares a bed with someone, it is wise to treat the bedmate at the same time as the person with lice, even if no live

Disease	Incubation period	Transmission	Common symptoms	Recommendations
		and elementary school, and is not a sign of poor hygiene.	asymptomatic.	lice are found. No exclusion necessary. Routine classroom or school-wide screening for lice is discouraged. Parents who are educated on the diagnosis of lice infestation may screen their own children's heads for lice regularly and if the child is symptomatic. Refer for treatment if infested.
Pertussis† (Whooping Cough) **All suspected or confirmed cases are rapidly reportable to the local health department**	7–10 days (Range: 5–21 days)	Close contact through large respiratory droplets generated by coughing or sneezing.	Catarrhal stage: mild upper respiratory tract symptoms (e.g., common cold). Lasts 1–2 weeks. Paroxysmal stage: cough, usually coughing fits, characterized by inspiratory whoop (gasping) after repeated cough on the same breath, which commonly is followed by post-tussive emesis. Fever is absent or minimal. Older children may not have the whoop. Typically lasts 1–6 weeks, up to 10 weeks. Convalescent stage: symptoms wane gradually over weeks to months. Lasts 2–3 weeks.	**PATIENT:** Exclude from school and childcare setting until 5 days after initiation of appropriate antibiotic therapy. A 5-day course of azithromycin is usually treatment of choice and is also used for postexposure prophylaxis (PEP). Untreated individuals should be excluded until 21 days have elapsed from cough onset. If you have questions about pertussis treatment or postexposure prophylaxis, discuss with your local health department. **CONTACTS:** PEP is recommended for all household and close contacts (including children in childcare), people at high risk of severe pertussis (infants <12 months of age, people with certain pre-existing conditions), and those who will have contact with people who are high risk (including all people in childcare settings) within 21 days of exposure to infectious person, regardless of immunization status. All close contacts should be monitored closely for pertussis symptoms for 21 days after last contact with the infected person. Close contacts with cough should have medical evaluation. Exclude on first indication of symptoms pending evaluation by healthcare provider.
Pinworm (Enterobiasis, Oxyuriasis)	1–2 months	Direct transfer of infected eggs by hand from anus to mouth of the same person or another person, or indirectly through clothing, bedding, food, or other articles contaminated	Female pinworms live in the infected person's intestine and lay eggs at night on the skin around the anus. This causes itching around the anus. Repeated scratching can lead to bacterial skin infection. Pinworms can also move to the vaginal area and cause irritation. Infected	**PATIENT:** Exclusion not indicated. **CONTACTS:** Exclusion not indicated. Consider treating the patient's household contacts at the same time the patient is treated.

Communicable Disease Reference Chart for School and Childcare Facility Personnel*

Disease	Incubation period	Transmission	Common symptoms	Recommendations
		with parasite eggs. Reinfection is common.	people may have trouble sleeping. Some people do not have symptoms.	
Ringworm (Body: Tinea Corporis, Scalp: Tinea Capitis, Groin: Tinea Cruris, Feet: Tinea Pedis)	1–3 weeks Can be shorter, as reported cases have occurred at 3 days of age.	Skin-to-skin contact with lesions of infected persons or animals, shared objects (e.g., brushes, combs, hats, towels), shared surfaces (e.g., locker room floors), soil or fomites	Circular, red to brown, well-demarcated skin lesion(s). May have a scaly, vesicular, or pustular border with central clearing. Small confluent plaques or papules can occur. Itching is common.	**PATIENT:** Exclusion not indicated if child is receiving treatment. Child does not need to be sent home early from school but should begin treatment before returning. Cover lesions if able. (Scalp lesions do not need head coverings.) **CONTACTS:** Exclusion is not indicated.
Rubella† (German Measles) **All suspected or confirmed cases are rapidly reportable to the local health department**	17 days (Range: 12–23 days)	Direct or droplet contact from nasopharyngeal secretions. Most contagious when the rash is erupting, but communicable for 7 days before onset of rash and at least 7 days after onset of rash.	Mild, maculopapular rash with swollen lymph nodes (often behind ear or at base of skull) and slight fever. Rash usually starts on face and spreads to the rest of the body within 24 hours. Rash typically lasts 3 days. Joint pain may occur, especially in older children and adults.	**PATIENT:** Exclude from school and childcare setting for 7 days after onset of rash. Avoid exposure to pregnant women. Check immunization records of all students. Discuss with your local health department. **CONTACTS:** In outbreak setting, children without evidence of immunity should be excluded for 23 days after onset of rash of the last case in the outbreak. Unvaccinated persons who receive MMR vaccine may be readmitted if all persons without documentation of immunity have been excluded Pregnant contacts should be evaluated by a healthcare provider.
Scabies	Persons without previous exposure: 4–6 weeks Previously infested and sensitized: 1–4 days	Prolonged close, personal contact. Infection from dogs/animals is uncommon. Casual skin contact is unlikely to result in transmission. Fomites are not likely to lead to classic scabies but can transmit crusted scabies because the parasite burden is much higher. (Crusted scabies is a severe, very contagious form that can occur in	Intensely itchy, red pimple-like rash around finger webs, wrists, elbows, knees, armpits, shoulder blades, waist, thighs, buttocks and/or genitalia. In children <2 years of age areas such as the scalp, face, neck, palms, and soles may be involved. Burrows are thin, gray or white, thread-like lines. Extensive scratching can result in secondary infection.	**PATIENT:** Exclude from school and childcare setting until after the first course of appropriate treatment has been completed. Children identified during the school day should not be sent home early from school or childcare setting because scabies has a low contagion within classrooms. **CONTACTS:** Close contacts with prolonged skin-to-skin contact should receive treatment at the same time the infected person does. Bedding and clothing in contact with the skin of infected people should be laundered in a washer with hot water and dried on a hot cycle.

Communicable Disease Reference Chart for School and Childcare Facility Personnel*

Disease	Incubation period	Transmission	Common symptoms	Recommendations
		those with chronic conditions, developmental disabilities, or weakened immune systems.)		
Group A Streptococcal (GAS) Diseases (Including Impetigo, Invasive GAS or toxic shock†, Streptococcal pharyngitis "Strep throat", and Scarlet Fever)	Impetigo: 7–10 days Strep throat/ Scarlet Fever: 2–5 days	Impetigo: Direct contact with skin lesions or their discharge. Strep throat/Scarlet fever: Respiratory droplets or contact with respiratory secretions. Fomite transmission and foodborne outbreaks are uncommon but can occur.	Impetigo: Red, itchy sores that break open and leak clear fluid or pus, then develop a honey-colored crust. Commonly found on the arms, legs, mouth and nose. Strep throat: Sudden onset of fever, sore throat, tonsil inflammation, palatal petechiae, strawberry tongue, and enlarged anterior cervical lymph nodes. Scarlet Fever: A sandpaper-like rash that occurs with strep throat (or rarely with an infected wound).	**PATIENT:** Impetigo: Exclude from school and childcare setting until at least 12 hours after antibiotic treatment has started and all sores on exposed skin are covered. Close contact with other children should be avoided during this time. Strep throat: Exclude from school and childcare until 12 hours after appropriate antibiotic therapy has been started AND afebrile without the use of fever-reducing medications (e.g., acetaminophen or ibuprofen). **CONTACTS:** Impetigo: Exclusion not indicated. Strep throat: Symptomatic contacts should be medically evaluated and treated if positive. Routine lab testing or school/childcare setting exclusion of asymptomatic household contacts is not indicated except during outbreaks or if the contact is at high risk of developing sequelae of infection. In general, chemoprophylaxis against Group A Strep is not recommended in school/childcare settings.
Tuberculosis† (Latent TB Infection or LTBI)	TB bacteria can become active weeks to years after initial infection. Without treatment, approximately 10% of people with LTBI will develop TB disease over their lifetimes.	LTBI is infection without any clinical symptoms. People with LTBI cannot spread to others, but LTBI can develop into active TB. Once active, TB can spread from person to person through the air (see below).	People with LTBI do not have symptoms.	**PATIENT:** Exclusion not indicated. A source case investigation to identify the source of the LTBI is usually only conducted if the LTBI occurs in a very young child (aged <5 years).

Communicable Disease Reference Chart for School and Childcare Facility Personnel*

Disease	Incubation period	Transmission	Common symptoms	Recommendations
Tuberculosis† (Active TB) **All suspected or confirmed cases of active tuberculosis are rapidly reportable to the local health department**	TB bacteria can become active weeks to years after initial infection.	Airborne spread through inhalation of aerosolized droplets generated when a person with pulmonary or laryngeal TB coughs, sneezes, talks, or sings. Children with TB are usually not contagious.	Pulmonary TB: cough, pain in the chest, coughing up blood, fever, weight loss or poor weight gain, night sweats, and fatigue. Young children may also show failure to thrive. Extrapulmonary TB: can affect any organ or tissue, including lymph nodes, bones and joints, meninges, and gastrointestinal tract. Symptoms depend on site of infection. Usually is not infectious.	**PATIENT:** Exclude from school and childcare setting until appropriate therapy has been started, adherence to therapy has been documented, and clinical symptoms improving. In consultation with the local health department, the clinical team will determine when it is appropriate for the child to resume activities. Young children are rarely infectious. **CONTACTS:** Evaluate for level of exposure and test for TB infection or disease as appropriate. Exposed contacts with weakened immune systems and all contacts aged <5 years should be treated while ruling out TB (this is called window prophylaxis) even if initial TB test is negative because of potential for decreased immune response. Re-test in 8–10 weeks after last exposure. Window treatment can usually be discontinued if the repeat test result is negative. Consult with your local health department for advice on management of patient and contacts.

*NOTE: These recommendations apply only to children in K-12 schools or childcare setting. A more complete discussion of these conditions and other communicable diseases may be found in *Control of Communicable Diseases Manual, 21st Edition* (2022) published by the American Public Health Association and the *2024-2027 Report of the Committee on Infectious Diseases, 33nd Edition* (*The Red Book*) published by the American Academy of Pediatrics. Additional information and consultation are also available through your local health department, especially for outbreaks and reportable conditions. School divisions may develop local policies for condition-specific recommendations.

† Disease is on the Virginia Reportable Disease List. Those required to report suspected or confirmed cases of diseases on the list to the local health department are described in 12VAC5-90-90. They include physicians, laboratory directors, and the person in charge of a medical facility. The person in charge of a residential or day program, service, or a facility licensed or operated by any agency of the Commonwealth or a school, child care center, or summer camp is required to immediately report any suspected or confirmed outbreak to the local health department. The person in charge of the facility is encouraged to also report single cases of disease, especially rapidly reportable diseases, but this is not required. For more information, see 12VAC5-90-90.

Summary of Major Changes in the August 2026 Update:

- Mpox – updated reporting requirements for those required to report cases.
- Updated the footnote for diseases on the Virginia Reportable Disease List to clarify who is required to report suspected or confirmed cases and outbreaks.
- Updated several hyperlinks and overall formatting.

Summary of Major Changes in the August 2025 Update:

- Chickenpox – defined outbreak
- Conjunctivitis – clarified exclusion criteria for bacterial or viral conjunctivitis
- COVID-19 – updated reporting and exclusion criteria
- Diarrheal Diseases – updated that for STEC in a childcare setting, two negative stool specimens needed for clearance
- Hand, Foot, and Mouth Disease (Coxsackievirus, Enterovirus) – added entry
- Measles – updated exclusion criteria for contacts
- Mononucleosis – added entry
- Norovirus – added that can restrict based on symptoms without diagnosis from provider
- Pediculosis – added recommendation to treat bedmates even if no live lice found
- Pertussis – clarified PEP is recommended within 21 days of exposure to infectious person
- Pinworm – added entry
- Scabies – added that bedding and clothing should be laundered in hot washer and hot dryer
- Tuberculosis (TB) – added entries for latent TB and active TB