

Communicable Disease Reference Chart for School and Child Care Facility Personnel*

DISEASE	INCUBATION PERIOD	TRANSMISSION	COMMON SYMPTOMS	RECOMMENDATIONS
Chickenpox [†] (Varicella)	10–21 days, usually 14–16 days. (Incubation period in persons who receive VariZIG or IVIG extends through day 28.)	By direct contact with vesicular fluid or by airborne spread from respiratory tract secretions. Infectious from 1 to 2 days before rash onset until all lesions have dried/crusted over and no new lesions appear within a 24-hour period (average is 4–7 days).	Sudden onset with slight fever, other systemic symptoms and itchy eruptions which become vesicular (small blisters) within a few hours. Lesions commonly occur in successive crops, with several stages of maturity present at the same time. Typically, vesicular rash consisting of 250–500 lesions in varying stages of development (papules, vesicles) and resolution (crusting). Communicable for as long as 5 days (usually 1–2 days) before eruption of vesicles and until all lesions are crusted (usually 5 days). Communicability may be prolonged in people with weakened immune systems.	PATIENT: Exclude from school or child care until: <ul style="list-style-type: none"> Uncomplicated varicella: 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 or until vesicles become dry Avoid exposure to women in early pregnancy who have not had chickenpox and/or varicella vaccine. CONTACTS: Check vaccination status of contacts in school and child care and recommend vaccination if needed within 3 to 5 days after exposure. For exposed contacts without immunity, airborne and contact precautions from 8 until 21 days after exposure and until 28 days after for those who received VariZIG or IVIG. On appearance of symptoms, exclude from school and child care.
Conjunctivitis (Pink Eye)	Usually 1–3 days, but variable depending on the causative agent. May be bacterial, viral, allergic, or chemical/irritant.	By contact with discharge from the conjunctivae or contaminated articles, if the cause is bacterial or viral. Allergic and chemical causes are not contagious.	Pink or red eye with swelling of the eyelids and eye discharge. Eyelids may be matted shut after sleep. May involve one or both eyes.	PATIENT: Exclude from school or child care while symptomatic or until cleared to return by a healthcare provider. CONTACTS: Exclusion not indicated. Important to wash hands thoroughly after contact with eye drainage. Also, do not share any articles that have come into contact with the eyes.
COVID-19 [†] (Coronavirus disease 2019 caused by SARS-CoV-2 virus)	Usually 2–14 days.	COVID-19 spreads when an infected person breathes out droplets and very small particles that contain the virus. These droplets and particles can be breathed in by other people or land on their eyes, noses, or mouth. In some circumstances, they may contaminate surfaces they touch. Infected people are believed to be infectious 2 days prior to symptom onset through 10 days after symptom onset, with viral loads being higher earlier in the course of infection.	Patients may be asymptomatic. Patients who develop symptoms may have a wide variety of symptoms of variable severity: <ul style="list-style-type: none"> Fever and/or chills Cough Shortness of breath Headache Runny nose Fatigue Sore throat Muscle aches/body aches New loss of taste or smell Nasal congestion Nausea and vomiting Diarrhea 	PATIENT: Please refer to the VDH K12 Isolation and Quarantine Guidance . Depending on severity of illness, refer to a healthcare provider, urgent care center, or emergency department for further evaluation and treatment. CONTACTS: Please refer to the VDH K12 Isolation and Quarantine Guidance . Quarantine is no longer recommended for asymptomatic contacts. VDH K12 Isolation and Quarantine Guidance: https://www.vdh.virginia.gov/coronavirus/get-the-latest-guidance/k-12-education-and-child-care/

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

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		diminishes and is minimal by 1 week after onset of jaundice.	Symptoms typically last less than 2 months but can extend up to 6 months.	<p>up. Determine if contact meets criteria for HAV post-exposure prophylaxis (PEP).</p> <p>Childcare staff or attendees who might have been exposed to HAV in the past 2 weeks should be excluded for 7 weeks after last contact with the case during the infectious period, unless they receive PEP within 14 days of exposure or report immunity through vaccination or serology indicating previous disease.</p> <p>Contacts who are symptomatic and epidemiologically-linked to a laboratory-confirmed case meet the case definition and should be managed as a case, including appropriate investigation and exclusion.</p> <p>In a child care center, stress importance of proper handwashing. In facilities with diapered children, if 1 or more cases confirmed in child or staff attendees or 2 or more cases in households of staff or attendees, hepatitis A PEP should be administered within 14 days of exposure to all unimmunized staff and attendees. In centers without diapered children, hepatitis A PEP should be administered only to unimmunized classroom contacts of index case. Asymptomatic contacts may return after receipt of hepatitis A PEP.</p> <p>If questions about management of cases and/or contacts, please contact local health department.</p>
Hepatitis B [†]	From 45–160 days; average 90 days.	By direct contact with infected blood or body fluids. Transmission occurs when the hepatitis B virus enters the body through broken skin or mucous membranes. The risks of HBV acquisition when a susceptible child bites a child who has chronic HBV infection or when a susceptible child is bitten by a child with chronic HBV infection are unknown.	Developing symptoms of acute hepatitis are age-dependent. The spectrum of symptoms and signs is varied and includes subacute illness with nonspecific symptoms (e.g., anorexia, nausea, or malaise), clinical hepatitis with jaundice, or fulminant hepatitis.	<p>PATIENT: Follow advice of child’s healthcare provider and/or your local health department.</p> <p>CONTACTS: Exclusion not indicated.</p>
HIV Infection [†] and AIDS [†] (Acquired Immunodeficiency Syndrome)	Acute retroviral syndrome occurring in adolescents and adults following HIV acquisition occurs 7–14 days following viral acquisition and lasts for 5–7 days. Most patients are not ill enough to seek	(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	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	<p>PATIENT: Follow advice of child’s healthcare provider and/or your local health department.</p> <p>CONTACTS: Exclusion not indicated.</p>

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	<p>medical attention.</p> <p>The usual age of onset of symptoms is generally 12–18 months of age for untreated infants and children who acquire HIV infection through mother-to-child transmission. Some children become ill in the first few months of life, but others remain relatively asymptomatic for more than 5 years and, rarely, until early adolescence.</p>	<p>blood or blood products, (6) cases of HIV transmission have been reported from contact of non-intact skin with blood-containing body fluids</p>	<p>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).</p>	
Influenza	<p>Usually 1–4 days, with an average of 2 days.</p>	<p>Person-to-person by respiratory droplets created by coughing or sneezing. Another mode of transmission comes from contact with influenza virus from droplet-contaminated hands or surfaces, where it can remain for up to 24 hours, with transfer from hands to mucosal surfaces of the face. Airborne transmission via small-particle aerosols in the vicinity of the infectious individual also may occur.</p> <p>Patients may be infectious 24 hours before onset of symptoms. Viral shedding in nasal secretions usually peaks during the first 3 days of illness and ceases within 7 days but can be prolonged (10 days or longer) in young children and immunodeficient patients.</p>	<p>Sudden onset of fever, often accompanied by nonproductive cough, chills or rigors, diffuse myalgia, headache, and malaise. Subsequently, respiratory tract symptoms, including sore throat, nasal congestion, rhinitis, and cough, become more prominent. Less commonly, abdominal pain, nausea, vomiting, and diarrhea are associated with influenza illness. In some children, influenza can appear as an upper respiratory tract illness or as a febrile illness with few respiratory tract symptoms. In infants, influenza can produce a nonspecific sepsis-like illness picture, and in infants and young children, influenza can cause otitis media, croup, pertussis like-illness, bronchiolitis, or pneumonia. Acute myositis secondary to influenza can present with calf tenderness and refusal to walk.</p>	<p>PATIENT: Exclude from school and child care until at least 24 hours following resolution of fever without the use of fever-reducing medication(s).</p> <p>CONTACTS: Exclusion not indicated.</p> <p>Annual seasonal influenza vaccination for staff and children ≥ 6 months of age is strongly encouraged to prevent cases of influenza or lessen severity of illness.</p>
Measles [†] (Rubeola, Red Measles)	<p>Generally, 8–12 days from exposure to onset of symptoms. (Range of 7 to 21 days, average of 14 days between appearance</p>	<p>Direct contact with infectious droplets or by airborne spread through inhalation of infectious droplets when a person with measles coughs, sneezes, etc.</p>	<p>Characterized by fever, cough, coryza, and conjunctivitis, followed by a maculopapular rash beginning on the face and spreading cephalocaudally and centrifugally.</p>	<p>PATIENT: Exclude from school and child care until at least 4 days after appearance of the rash and when the child is able to participate.</p> <p>CONTACTS: Check immunization records of all contacts.</p>

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	<p>of rash among case and contacts)</p> <p>All suspected or confirmed measles cases are rapidly reportable to the local health department</p>	<p>Patients infected with wild-type measles virus are contagious from 4 days before the rash onset through 4 days after appearance of the rash.</p>	<p>During the prodromal period, a pathognomonic enanthem (Koplik spots) may be present. Sometimes the characteristic rash does not develop in patients with weakened immune systems.</p> <p>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.</p>	<p>Additional measures are not needed for children and/or staff who are fully vaccinated or have evidence of immunity to measles. People who have not been immunized, including those exempted from measles immunization for medical reasons, should be excluded from school, child care, and health care settings until at least 21 days after the onset of rash in the last case of measles. Discuss with your local health department. Every suspected measles case should be reported immediately to the local health department.</p>
<p>Meningitis, Bacterial (<i>H. influenzae</i>[†], Meningococcal[†], Pneumococcal)</p>	<p>In general, 1 to 10 days, usually less than 4 days.</p> <p><i>H. influenzae</i>: 2–4 days</p> <p>Meningococcal: 2–10 days, usually 3–4 days.</p> <p>Pneumococcal: 1–4 days</p> <p>All suspected or confirmed cases of invasive <i>H. influenzae</i> disease or meningococcal disease are rapidly reportable to the local health department</p>	<p>Transmission occurs from person to person through droplets from the respiratory tract and requires close contact. Transmission can also occur by sharing beverages, utensils, and personal care products. Patients should be considered capable of transmitting the organism for up to 24 hours after initiation of effective antimicrobial treatment.</p>	<p>Typically, acute onset of fever, neck stiffness, neck pain, headache, light sensitivity and other neurologic symptoms or signs.</p> <p>In meningococcal disease, rash initially can be macular or maculopapular but typically becomes petechial or purpuric within hours. Signs and symptoms of meningococcal meningitis are sometimes indistinguishable from those associated with pneumococcal meningitis.</p>	<p>PATIENT: Exclude from school and child care during acute illness. Non-communicable after 24-48 hours of appropriate drug therapy.</p> <p>CONTACTS: Exclusion not indicated. Discuss with your local health department to determine if close contacts need prophylactic treatment for <i>H. influenzae</i> or meningococcal meningitis, especially contacts in a child care setting. Students and staff should be advised not to share beverages, eating utensils, or personal care products.</p>
<p>Mpox[†] (Previously known as monkeypox)</p>	<p>Symptoms usually start within 3 weeks of exposure to the virus. If someone has flu-like symptoms, they will usually develop a rash 1–4 days later.</p>	<p>Transmission occurs through direct contact with sores, scabs, or body fluids from an infected person or animal, indirect contact with contaminated items (e.g., clothes, bedding, towels), and large respiratory droplet transmission during prolonged face-to-face contact.</p> <p>Mpox can be spread from the time symptoms start until the rash has healed, all scabs have fallen off, and a fresh layer of skin has formed. The illness typically lasts 2–4 weeks.</p>	<p>People with mpox get a rash that may be located on the hands, feet, chest, face, mouth, or other locations.</p> <p>The rash will go through several stages, including scabs, before healing. The rash can initially look like pimples or blisters and may be painful or itchy.</p> <p>Other symptoms of mpox can include fever, chills, swollen lymph nodes, exhaustion, muscle aches</p>	<p>PATIENT: Exclude from school and child care 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.</p> <p>CONTACTS: Exclusion not indicated in most cases. In some cases, if contact tracing may not be possible and there was a high 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</p>

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			<p>and backache, headache, respiratory symptoms (e.g., sore throat, nasal congestion, or cough).</p> <p>Sometimes, people have flu-like symptoms before the rash. Some people get a rash first, followed by other symptoms. Others only experience a rash.</p>	<p>interactions in the environment, and the risk of more severe disease to others in the setting.</p> <p>Settings that have children or adolescents in residence, like boarding schools, overnight camps, or other residential environments, should follow considerations for congregate settings.</p>
Mumps [†]	<p>From 12–25 days, usually 16–18 days.</p> <p>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.</p>	<p>Mumps is highly infectious. Transmission occurs by droplet spread or by direct contact with respiratory tract secretions or the saliva of an infected person.</p>	<p>Fever with swelling and tenderness of one or both parotid glands as well as nonspecific symptoms such as muscle aches, loss of appetite, malaise, headache, and low-grade fever. Asymptomatic infection occurs in about 15-20% of cases, usually in adults more than children.</p>	<p>PATIENT: In addition to standard precautions, exclude from school and child care for 5 days after the onset of parotid gland swelling.</p> <p>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 child care.</p> <p>If health department agrees, unimmunized contacts should be excluded until at least 26 days after onset of parotitis in the last person with mumps. Moreover, if the school or child care is considered to be at high risk for mumps, a recommendation may be made for students and staff who have had two doses of a mumps-containing vaccine to receive a third dose of MMR vaccine.</p>
Norovirus	From 12–48 hours	<p>Primarily by the fecal-oral route through direct contact or ingestion of contaminated food or water, or by touching contaminated surfaces. Transmission is also possible through direct contact with the vomit, exposure to contaminated surfaces and aerosolized vomitus of an infected person.</p>	<p>Sudden onset of vomiting and/or diarrhea, abdominal cramps, and nausea. Symptoms typically last from 24 to 72 hours but prolonged illness can occur. Systemic manifestations, including fever, myalgia, malaise, anorexia, and headache, may accompany gastrointestinal tract symptoms.</p>	<p>PATIENT: In addition to standard precautions, exclude from school and child care until 48 hours after symptoms resolve. Infants and children should be excluded from child care centers 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, especially when caring for diapered children, as virus may be shed in stool for weeks after symptoms resolve.</p> <p>CONTACTS: Exclusion not indicated.</p> <p>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.</p>

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Pediculosis (Head Lice)	Eggs hatch in about 1 week (range 6–9 days), and reach maturity to an adult about 7 days later.	By direct head-to-head contact with hair of an infected person. Transmission can occur by the personal belongings of an infected person, but this is uncommon. Head lice occurs most commonly in children attending child care, preschool, and elementary school, and is not a sign of poor hygiene.	Severe itching and scratching, often with secondary infection. Eggs of head lice (nits) attach to hairs as small, round, gray lumps. However, many children are asymptomatic. Excoriations and crusting caused by secondary bacterial infection may occur.	PATIENT: Notify parents; inform that child has lice and should be treated. Children should not be excluded or sent home early from school or child care 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. No exclusion necessary. Routine classroom or school-wide screening for lice is discouraged. Parents who are educated on the diagnosis of lice infestation may screen their own children’s heads for lice regularly and if the child is symptomatic. Refer for treatment if infested.
Pertussis† (Whooping Cough)	From 5–21 days, usually 7–10 days. All suspected or confirmed cases of pertussis are rapidly reportable to the local health department	By direct contact with large respiratory droplets (coughing, sneezing) of an infected person by the airborne route.	The initial stage begins with mild upper respiratory symptoms of a common cold and increasingly irritating cough. The paroxysmal stage usually follows within 1 to 2 weeks. “Classic” pertussis has a duration of about 6–10 weeks. Paroxysmal stage is characterized by repeated episodes of violent cough broken by a high-pitched inspiratory whoop and vomiting. Older children may not have whoop. Convalescence may require many weeks.	PATIENT: Exclude from school and child care until 5 days after initiation of appropriate antibiotic therapy. A 5-day course of azithromycin is usually treatment of choice and is also used for post-exposure prophylaxis. Untreated individuals should be excluded until 21 days have elapsed from cough onset. If questions about pertussis treatment or post-exposure prophylaxis, discuss with your local health department. CONTACTS: PEP may be indicated for certain high-risk individuals, including infants <12 months of age and household contacts, and for all people in high risk settings (e.g. child care centers) that include infants <12 months of age and other high risk individuals. Individuals in all settings who have been in close contact with a person infected with pertussis should be monitored closely for respiratory tract symptoms for 21 days after last contact with the infected person. Close contacts with cough should have medical evaluation. Exclude on first indication of symptoms pending evaluation by healthcare provider.
Ringworm of the Body (Tinea Corporis)	Incubation period believed to be 1 to 3 weeks but can be shorter, as reported cases have occurred at 3 days of age.	By contact with lesions of infected persons, animals, soil or fomites (e.g., brushes, combs, hats, towels).	Circular, red to brown, well-demarcated lesion that can involve face, trunk, or limbs. The classic eruption displays a scaly, vesicular, or pustular border (often serpiginous) with central clearing. Small confluent plaques or papules as well as multiple lesions can occur. Itching is common.	PATIENT: Exclusion not indicated as long as lesions are covered or child is receiving treatment. CONTACTS: Exclusion is not indicated.
Rubella† (German Measles)	From 12 to 23 days, usually 17 days. All suspected or confirmed cases of	By direct contact or droplet spread of nasopharyngeal secretions of an infected person. People infected with rubella are most contagious when the rash is erupting.	Mild symptoms; slight fever, rash of variable character lasting about 3 days; enlarged head and neck lymph glands commonly lasting between 5 to 8 days. Joint pain may	PATIENT: Exclude from school and child care for 7 days after onset of rash. Avoid exposure to women in early pregnancy. Check immunization records of all students. Discuss with your local health department.

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	rubella are rapidly reportable to the local health department		occur, especially in older children and adults. Communicable for 7 days before onset of rash and at least 7 days thereafter.	CONTACTS: In outbreak setting, children without evidence of immunity should be immunized or excluded for 23 days after onset of rash of the last case in the outbreak. Pregnant contacts should be evaluated.
Scabies	Persons without previous exposure: 4 to 6 weeks. Previously infested and sensitized: 1–4 days after re-exposure.	By direct skin-to-skin contact, usually prolonged exposure. Infection from dogs or other animals is uncommon. Casual skin contact unlikely to result in transmission. Fomite transmission not likely to lead to classic scabies, but fomite transmission more likely in setting of crusted scabies since parasite burden is much higher.	Begins as itchy raised areas around finger webs, wrists, elbows, armpits, belt-line, thighs, naval, abdomen, buttocks and/or genitalia. In older children and adults, in areas such as the scalp, face, neck, palms, and soles. Scabitic burrows appear as thin, gray or white, serpiginous, thread-like lines. Extensive scratching often results in secondary infection. Crusted scabies (also known as Norwegian scabies) can occur in people who have deficiency in cellular immunity (AIDS, lymphoma, long-term steroid use, etc.).	PATIENT: Exclude from school and child care 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 child care because scabies has a low contagion within classrooms. CONTACTS: Close contacts with prolonged skin-to-skin contact should receive treatment at the same time the infected person does. Bedding and clothing in contact with skin of infected people should be laundered.
Streptococcal Diseases (Including Impetigo, Scarlet Fever, and Streptococcal pharyngitis)	Some common Group A Streptococcal infections include (1) impetigo, (2) streptococcal pharyngitis (“strep” throat) and (3) Scarlet fever. Typical incubation periods are as follows: Impetigo: 7–10 days Streptococcal pharyngitis: 2–5 days Scarlet fever: generally occurs in conjunction with streptococcal pharyngitis	In impetigo, usually acquired by direct contact with skin lesions or their discharge from an infected person. Strep pharyngitis/Scarlet fever: By direct contact with infected persons and carriers or by contact with their respiratory droplets.	Impetigo: Multiple skin lesions usually of exposed area (e.g., elbows, legs, and knees), but may involve any area. Lesions vary in size and shape, and begin as blisters, which rapidly mature into brown crusts on a reddened base. Healing from center outward produces circular areas, which may resemble ringworm. Scarlet Fever: Fever, sore throat, exudative tonsillitis or pharyngitis. Sandpaper-like rash appears most often on neck, chest, and skin folds of arms, elbows, groin, and inner aspect of thighs. “Strep” throat: Sudden onset of fever, sore throat, exudative tonsillitis or pharyngitis, and enlarged lymph nodes. Symptoms may be absent in some cases.	PATIENT: For impetigo: Exclude from school and child care until at least 12 hours after antibiotic treatment has been started and all sores on exposed skin are covered. Close contact with other children should be avoided during this time. For Group A strep pharyngitis: Exclude from school and child care 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: For impetigo: Exclusion not indicated. Stress good handwashing. For Group A Strep pharyngitis: Symptomatic contacts of a child with documented Group A Strep infection with recent or current clinical evidence of a Group A Strep infection should be medically evaluated and treated if positive. Routine lab testing or school/child care exclusion of asymptomatic household contacts is not indicated except during outbreaks or if the contact is at high risk of developing sequelae of infection. In general, in the school and child care setting, chemoprophylaxis against Group A Strep is not recommended.

NOTE: THESE RECOMMENDATIONS APPLY ONLY TO CHILDREN IN K-12 SCHOOLS OR CHILD CARE - A more complete discussion of these conditions and other communicable diseases may be found in *Control of Communicable Diseases Manual (2022)* published by the American Public Health Association and the *2021 Report of the Committee on Infectious Diseases (The Red Book)* published by the American Academy of Pediatrics. Additional information and consultation are also available through your local health department.

*Please see last page for a summary of major changes.

† Officially reportable in Virginia to the local health department. All outbreaks and unusual occurrences of disease are also reportable.

Summary of Major Changes in the February 21, 2023 Update:

- Conjunctivitis (Pink eye) – Expanded from “acute bacterial” conjunctivitis to “all causes,” removed the requirement to be on antibiotics to return to school/child care, and added clearance by a healthcare provider to return while symptomatic.
- COVID-19 – Aligned transmission information with the Centers for Disease Control and Prevention (CDC). Removed information on close contacts.
- Fifth Disease (Parvovirus B19) – Added information about the characteristic rash.
- Hepatitis A – Clarified length of exclusion for patients who are food handlers and those who work in or attend child care.
- Mpox – Updated disease name from “monkeypox” to “mpox.”
- Pertussis – Aligned PEP recommendations for contacts with CDC recommendations.
- Rubella – Updated exclusion of unimmunized contacts from 21 days to 23 days.
- Streptococcal Diseases – Changed exclusion criteria from 24 hours of antibiotics to 12 hours of antibiotics for impetigo, and to 12 hours of antibiotics AND afebrile for strep pharyngitis.

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