COMMUNICABLE DISEASES IN SCHOOLS

Reference Guide

Los Angeles Unified School District
Medical Services Division
Student Medical Services Branch
District Nursing Services Branch
5th Edition
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PART I:
INTRODUCTION TO COMMUNICABLE DISEASE IN SCHOOLS

OVERVIEW

Our students spend a lot of time in the school setting. Schools prioritize attendance, which is necessary for optimal student learning and achievement. Yet, the close, confined contact among students and staff makes transmitting infectious diseases possible. Determining the likelihood that an infection will spread from one person to another requires an understanding of the ease and mechanism by which a particular organism is transmitted, as well as some knowledge of the host immunity (i.e., vaccination status, compromised immune system, etc.). We must also recognize that many schools do not have a full-time health professional on-site, and some students have limited access to medical services. This makes it important to have references for administrators and staff (including licensed nursing staff and physicians) to make informed decisions when intervening in communicable disease cases.

This Reference Guide has been compiled using existing District publications along with the most current available information from the American Academy of Pediatrics and the Center for Disease Control and Prevention (CDC). In addition, current State, County, and Los Angeles Unified School District (LAUSD) policies are reflected in this Reference Guide. The changing nature and evolving understanding of communicable diseases, particularly with the transmission of new disease entities between countries, makes it important to stay abreast of local disease patterns and infection control policies. District personnel are advised to contact the Communicable Disease (CD) Desk at District Nursing Services if there are any questions regarding the management of communicable diseases in schools.

The Reference Guide is designed to be a quick reference for LAUSD personnel. The following sections describe general recommendations for inclusion/exclusion and readmission to school due to illness. There is also a section defining the terms used in this Reference Guide. **Part II** references the various policies related to controlling communicable diseases in school. **Part III** catalogues common infectious diseases in alphabetical order, offering general information and specific exclusion, readmission, and contact guidelines for school settings. **Part IV** addresses and provides guidance on uncommon communicable diseases. **Part V** summarizes bioterrorism and includes a table describing early clinical signs of certain infectious agents that could be used in a bioterrorist attack. The appendices found in **Part VI** give more specific information about communicable disease control, including District bulletins and reference sheets and forms from other agencies. All of this is to keep students, staff, and families healthy and able to participate fully in the educational process.

GENERAL INCLUSION AND EXCLUSION CRITERIA

Determining when to include and exclude students from school is a difficult decision, particularly as there are varied factors that influence the decision. On the one hand, schools are inclusive institutions that accommodate children with various medical issues. Student attendance is linked to academic achievement; therefore, avoiding unnecessary exclusion is important for student success. On the other hand, children and adolescents who attend school with a communicable disease put others at risk. Fortunately, most of the commonly encountered infections in school-age children are relatively harmless.

This Reference Guide is designed to help staff make an informed decision about when to exclude students from the school setting. School personnel cannot determine a diagnosis but can recognize symptoms of a communicable disease in a student. Staff are encouraged to use what is presented in this Guide and their best judgment to help ensure a safe and healthy school environment.

Below is the **"General Exclusion Criteria for Schools"** containing the following: **Table 1** lists emergencies that require automatic exclusion and emergency care. **Table 2** lists conditions requiring immediate medical attention and exclusion from school until evaluated by their primary care provider. **Table 3** lists conditions requiring temporary exclusion and may not require an evaluation from their primary care provider. In addition, California law requires exclusion if a student's immunization status does not comply with Health and Safety Code (Division 105) and Administrative Code (Title 17) regulations. Effective January 1, 2016, State law does not allow personal or religious belief exemptions from immunization. There are other situations where students can be admitted "conditionally" (see Attachment B, "Immunization Status and School Admission Quick Reference," in BUL-1660.10, *Immunization Guidelines for School Admission*, dated December 2, 2024). *Remember, most illnesses do not require exclusion*.

Readmission to school after exclusion for a communicable disease falls to the school principal or principal's designee. This could be the school nurse or other staff designated to assist injured or ill students on campus. There may be instances where certain readmission criteria should be met, and these are delineated in the listings of each communicable disease (Part III). In more serious cases of infection, the attending licensed healthcare provider or the local health department should clear the student in writing before readmission.

GENERAL EXCLUSION CRITERIA FOR SCHOOLS[1]

Table 1	
Call emergency medical services for a student who:	• Has difficulty breathing or is unable to speak, rapid breathing, pursed lips. • Has blue, purple, gray skin or lips. • Is increasingly less responsive or unconscious. • Is vomiting blood. • Has signs of meningitis (stiff neck, fever[2] and headache). • Is severely dehydrated (lethargic, sunken eyes, no urine). • Has a serious injury or is experiencing severe pain. • Is acting very strangely, less alert, or very withdrawn. • The child's life seems to be at risk or there is a risk of permanent injury. • The child has rapidly spreading raised red skin areas with throat-closing, tongue swelling, trouble breathing or wheezing, or decreased consciousness (severe allergic reaction—anaphylaxis). • The child has rhythmic jerking of arms and legs and loss of consciousness (seizure). • After a head injury, the child has any of the following signs or symptoms: decrease in level of alertness, confu-sion, headache, vomiting, irritability, difficulty walking. • The child has a cut or a burn that is large or deep or won't stop bleeding. • The child is significantly dehydrated (e.g., sunken eyes, lethargic, not making tears, not urinating). • Multiple children are affected by injury or serious illness at the same time. • When in doubt about whether to call EMS (911), make the call. After calling EMS (911), call the child's parent/legal guardian.

Table 2	
Seek immediate medical attention (within one hour) for a student who:	• Has a fever[2] and looks more than mildly ill. • Has a large volume of blood in the stools. • Has an injury that may require medical treatment, such as a deep cut that may require stitches. • Has an animal or human bite that breaks the skin. • Has any medical condition that is outlined in the child's care plan as requiring medical attention. • Temperature above 100.4 °F (38.0 °C) by any method. • A quickly spreading purple or red rash or a rapidly spreading rash that raises concern for an allergic reaction (e.g., hives).

Table 3	
Temporarily exclude a student if there is:	• An illness that prevents the student from participating comfortably in school activities. • An illness that results in a need for care that is greater than the staff can provide without compromising the health and safety of other students. • An illness that poses a risk of spreading disease to others. • Fever[2] and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). • Diarrhea[3]: exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing "accidents." Exclude children whose stool frequency exceeds 2 stools above typical for that child while the child is in the program or whose stool contains more than a drop of blood or mucus. • Vomiting more than 2 times in the previous 24 hours, unless the vomiting is determined by a pediatric health professional to be from a non-communicable condition, and the child is not in danger of dehydration. • Abdominal pain that continues for more than 2 hours or intermittent pain associated with fever or other signs and symptoms. • Mouth sores with excessive drooling that the child cannot control and unless the child's primary health professional or local health department authority states the child is noninfectious. • Rash with fever or behavioral changes, or has a persistent rash, until a primary health professional has determined the illness is not a communicable disease. • Skin sores that are weeping fluid and are on an exposed body surface that cannot be covered with a waterproof dressing. • A severely ill appearance. Symptoms could include lethargy or lack of responsiveness, irritability, persistent crying, difficulty breathing, or having a quickly spreading rash. • Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection): exclusion until the child has received an appropriate antibiotic for 12 hours.

Table 3 (continued)	
	• Head lice: only if child has not been treated after notifying family at the end of the prior program day. (Note: Exclusion is not necessary before the end of the program day.) • Scabies: only if child has not been treated after notifying family at the end of the prior program day. (Note: Exclusion is not necessary before the end of the program day.) • Ringworm: only if child has not been treated after notifying family at the end of the prior program day. (Note: Exclusion is not necessary before the end of the program day.) • Impetigo: only if child has not been treated after notifying family at the end of the prior program day. (Note: Exclusion is not necessary before the end of the program day as long as lesions are covered.) • Chickenpox (varicella): until all lesions have dried or crusted (usually 6 days after onset of rash) and no new lesions have appeared for at least 24 hours. • Rubella: 7 days after the rash appears. • Whooping Cough (pertussis): 5 days after appropriate treatment (antibiotic); 21 days from onset of cough, if untreated. • Mumps: 5 days after onset of parotid gland swelling. • Measles: 4 days after the onset of rash. • Hepatitis A virus infection: 1 week after onset of illness or jaundice or as directed by the health department (if the child's symptoms are mild). • Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

1. Adapted from Timothy R. Shope and Andrew N. Hashikawa, Eds., *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide*, 6th Ed. (Itasca, IL, American Academy of Pediatrics, 2023).

2. See definition of fever (next page)

3. See definition of diarrhea (next page)

DEFINITIONS OF TERMS

Bacteria: Organisms that may be responsible for localized or generalized diseases and can survive in and out of the body. They can be treated effectively with antibiotics.

Bloodborne pathogens: Apply to blood and other body fluids containing blood, semen, and vaginal secretions—but *not* stool, nasal secretions, sputum, sweat, tears, urine, saliva, or vomitus, unless they contain visible blood or are likely to contain blood.

Body fluids: Urine, stool, saliva, blood, nasal discharge, eye discharge, and tissue discharge (i.e., seepage from wound). Not all body fluids transmit all types of micro-organisms.

Close contact: A close contact is a person sharing the same indoor airspace during the confirmed case's infectious period regardless of the use of face coverings. For indoor space under 400,000 cubic feet: 15 cumulative minutes or more over a 24-hour period. For indoor space over 400,000 cubic feet: within 6 feet for a total of 15 minutes or more over a 24-hour period. Spaces separated by floor-to-ceiling walls (for example, offices, suites, rooms, waiting areas, bathrooms, or break rooms separated by floor-to-ceiling walls) must be considered distinct indoor spaces.

Communicable disease: A disease caused by a micro-organism (e.g., bacteria, virus, fungus, parasite) that can be transmitted from person to person by an infected body fluid or respiratory spray. This may occur with or without an intermediary agent (e.g., mosquito) or object (e.g., table surface).

Confirmed case: An individual diagnosed with a disease by a licensed health care provider (MD, DO, NP, PA) with written verification or proof of a confirmatory laboratory test.

Dermatitis: An inflammation of the skin caused by irritation or infection.

Diarrhea: More frequent loose or watery stools (2 stools more than typical) compared to the student's normal pattern (not associated with a change in diet or use of medications). Exclusion may be needed if diarrhea cannot be contained in the toilet/diaper or there are other signs, such as blood or color change (black).

Fever: An elevation of the body temperature. While there are several definitions of fever, for the purpose of evaluating a student in school, fever is defined as temperature of $\geq$ 100.4°F (38°C) oral, temporal, or ear. Fever is an indication of the body's response to something but is neither a disease nor a severe problem by itself.

Fungi: Plantlike organisms such as yeasts, molds, mildews, and mushrooms that get nutrition from other living organisms or dead organic matter.

Immunizations: Vaccines that are given to children and adults to help them develop protection (antibodies) against specific infections. Vaccines may contain an inactivated or killed agent or a weakened live organism.

Incubation period: Time between exposure to an infectious microorganism and beginning of symptoms.

Isolation: Physical separation of a person with a confirmed infectious disease from people who are not infected.

Mantoux intradermal skin test: Involves the injection of a standard amount to tuberculin protein under the skin. The reaction to the protein on the skin can be measured and the result is used to assess the likelihood of infection with tuberculosis.

Over the Counter Medications (OTC) or non-prescription medicine: Medicine that can be bought without a prescription.

Parasite: An organism that lives on or in another living organism (e.g., tick, louse).

Pelvic Inflammatory Disease (PID): Infection of one or more of the upper reproductive organs, including uterus, fallopian tubes and ovaries.

Universal precautions: Universal precautions include avoiding injuries caused by sharp instruments or devices and the use of protective barriers such as gloves, gowns, masks, and protective eyewear, which can reduce the risk of exposure of a worker to materials that may contain blood-borne pathogens while the worker is providing first aid or care.

Virus: A microscopic organism that may cause disease. Viruses can grow or reproduce only in living cells.

PART II:
POLICIES ON THE CONTROL OF COMMUNICABLE DISEASE IN SCHOOLS

POLICIES CONCERNING COMMUNICABLE DISEASES IN SCHOOLS

The health and safety of the students is guided by several policies, some are LAUSD- specific and others are part of California health, administrative and educational codes. Listed below are some of the pertinent policies for communicable disease identification, reporting, treatment, and prevention. While these are provided for reference, it should be noted that policies cannot cover every possible individual scenario. It is each staff member's responsibility to use good judgment when dealing with communicable diseases. Student Medical Services Branch and District Nursing Services Branch (Communicable Disease Team) are available for consultation and should be used as a resource when there is any question regarding communicable disease diagnosis, exclusion, reporting, readmission, and notification criteria.

Contact Information for Communicable Diseases**:**

Communicable Disease Desk .....(213) 202-7576
District Nursing Services Branch .....(213) 202-7580
Student Medical Services Branch.....(213) 202-7584

Exclusion of students with communicable disease

- "A pupil while infected with any contagious or infectious disease may not remain in any public school." (*California Code of Regulations, Title 5, Education, 202*.)

- "The governing body of any school district may exclude children of filthy or vicious habits, or children suffering from contagious or infectious diseases." (*California Education Code, 48211*)

- "Students showing signs and symptoms of communicable or infectious diseases shall be excluded from attending school. The Medical Services Division, in cooperation with the County of Los Angeles, Department of Health Services, shall prescribe such measures as shall be necessary for the control of communicable diseases, including the exclusion and readmission of students. (For provisions relating to employees, see Board Rule 1942.) Students whose continued presence would constitute a clear and present danger to the life, safety, or health of other students or school personnel shall be exempted or excluded." *(LAUSD Board Rule 2312)*

- "It shall be the duty of the principal or other person in charge of any public, private or Sunday School to exclude therefrom any child or other person affected with a disease presumably communicable, until the expiration of the prescribed period of isolation for the communicable disease. If the attending physician, school physician, or health officer finds upon examination that the person is not suffering from a communicable disease, he may submit a certificate to this effect to the school authority who shall readmit the person." *(California Code of Regulations, Title 17, Public Health, 2526)*

Exclusion of school employees with communicable disease

- "… [regarding communicable disease] … applicants and employees with any acute or chronic (e.g., tuberculosis AIDS/HIV infection) communicable diseases which may endanger health or safety of self

and/or others, shall be evaluated on an individual basis in relation to the successful performance of the core duties of the class for which applying or in which serving…" *(LAUSD Board Rule 1942)*

Reporting communicable diseases

A list of reportable diseases for the County of Los Angeles Public Health is included in Appendix A, "Reportable Diseases and Conditions," of this Reference Guide. *All reporting of communicable disease within LAUSD is coordinated by the District Nursing Services Branch, Communicable Disease Unit, and Student Medical Services Branch.* Please use the phone numbers listed on the previous page to receive information and assistance with a communicable disease case on a school campus.

"It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed in [Appendix A], to report to the local health officer for the jurisdiction where the patient resides... Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed in [Appendix A] may make such a report." *(California Code of Regulations, Title 17, section* 2500*)*

Please note: "Health care provider" includes physicians, surgeons, nurse practitioners, physician assistants, registered nurses, school nurses, infection *control practitioners, dentists, and others as specified in subsections (h) in Title 17 section 2500.*

"It shall be the duty of anyone in charge of a public or private school, kindergarten, boarding school, or day nursery to report at once to the local health officer the presence or suspected presence of any of the communicable diseases." *(California Code of Regulations, Title 17, section 2508)*

Notification of communicable disease

All schools must consult the Communicable Disease (CD) Desk at the District Nursing Services Branch regarding communicable disease concerns/possible outbreaks. The CD Nurses will determine if the disease meets the criteria for reporting. If required, the CD Nurses will report the disease to the Los Angeles County Department of Public Health (LACDPH). The CD Nurse will notify District Nursing Services Branch Administration, Student Medical Services Branch, Chief Medical Director and Region Operations of the reporting of communicable diseases to LACDPH.

Immunizations

Immunization is an important method of preventing certain communicable diseases, especially in group settings such as schools and childcare. The California School Immunization Law requires children to have a series of immunizations before they enter school (public and private elementary and secondary schools).

See BUL-1660.10, *Immunization Guidelines for School Admission*, and *California Immunization Handbook For Pre-kindergarten (Child Care) Programs and Schools*, 13th edition, revised July 2025, California Department of Public Health (CDPH). Please refer to Appendix B, "Immunizations Requirements for TK – 12 Schools," in this Reference Guide.

- "… the governing board of any school district shall cooperate with the local health officer in measures necessary for the prevention and control of communicable diseases in school age children. For that purpose, the board may use any funds, property, and personnel of the district, and may permit any person licensed as a physician and surgeon, or any person licensed as a registered nurse acting under the direction of a supervising physician and surgeon … to administer an immunizing agent to any pupil whose parents have consented in writing to the administration of such immunizing agent." *(California Education Code 49403)*

Tuberculosis

- Effective July 1, 2012, schools shall not require a TB skin test for kindergarten or first grade entry. In addition, any student entering any other grade level who has not attended a California school will not be subject to a mandate for TB skin testing. Instead, entering students will be screened for risk of disease as part of their regular childcare and school entry exam or pediatric physical exams. Well-child and school-entry exam providers will target their testing to those at increased risk for TB. Screening procedures and guidance on this topic are available to providers through the LACDPH, the CDPH, the CDC, and other national organizations.

- If a TB test is given during a Tuberculosis follow-up (contact investigation) program, a consent slip, provided by the LACDPH of Public Health, shall be completed and be on file at the school before a TB test may be given. However, a minor child over the age of 12 may give consent for the TB testing (California Family Code Section 6926). If the test is positive, it shall be followed by an X-ray of the chest.

Exposure control plan and general sanitation

- "Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials…" and "Each employee shall ensure that the worksite is maintained in a clean and sanitary condition." (*Bloodborne Pathogens Exposure Control Plan*, dated March 2017).

- "Clean all contaminated areas and materials first with soap/detergent and water. An LAUSD approved commercial product may be used for cleaning surfaces which are not contaminated with blood…" (Approved chemical product list for use in the District can be found at https://achieve.lausd.net/oehs. "For washable surfaces always use freshly made 1:10 bleach solution (1 part bleach to 9 parts cold water) when cleaning up blood." (BUL-1645.3, *Infection Control Guidelines for Preventing the Spread of Infectious Diseases*, dated December 1, 2025).

PART III:
COMMONLY ENCOUNTERED COMMUNICABLE DISEASES

BED BUGS

1. **What are Bed Bugs?** Bed bugs (*Cimex lectularius*) are small, flat, parasitic insects that feed solely on the blood of people and animals while they sleep. Bed bugs are reddish-brown in color, wingless, range from 1mm to 7mm (roughly the size of Lincoln's head on a penny), and can live several months without a blood meal.

2. **Where are Bed Bugs Found?** Bed bug infestations usually occur around or near areas where people sleep. These areas include apartments, shelters, rooming houses, hotels, cruise ships, buses, trains, and dorm rooms. They hide during the day in places such as seams of mattresses, box springs, bed frames, headboards, dresser tables, inside cracks or crevices, behind wallpaper, or any other clutter or objects **around** a bed. Bed bugs have been shown to be able to travel over 100 feet in a night but tend to live within 8 feet of where people sleep.

3. **What Health Risks to Bed Bugs pose?** A bed bug bite affects each person differently. Bed bug bites usually do not pose a serious medical threat. Bite responses can range from an absence of any physical signs of the bite to a small bite mark to a serious allergic reaction. Bed bugs are not considered to be dangerous; however, an allergic reaction to several bites may need medical attention.

4. **What should you do if you think you discovered bed bugs in a school?** Place the insect in a crush-proof container or a zip lock bag or apply a piece of tape to the insect and then stick the tape on a clean, white sheet of paper, try not to crush the insect. Have the principal, assistant principal, or plant manager place an emergency work order request to the LAUSD Facilities Services Division, Maintenance and Operations, Pest Management Unit for evaluation of the situation at:
   Central (M&O C-3) ..... (213) 745-1400
   Region North (M&O N-2)..... (818) 394-2400
   Region South (M&O S-1)..... (323) 789-5000
   Note: There are other insects that can be confused with bed bugs.

5. **What should you do with a person who may have brought bed bugs to a school or work location?** The law does not permit anyone, other than law enforcement officers, to search a person or a person's belongings, even if you are just looking for bed bugs. If you are certain bed bugs emerge from a backpack, a lunch bag, or a jacket or coat, these items can be placed in a trash bag that is then tied to confine the infestation.

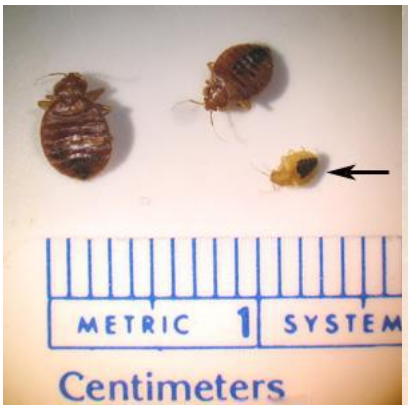
6. **Exclusion:** NONE. If it is confirmed by a District Pest Management Technician that a student's belongings are infested, the parents or guardians should be contacted by the site administrator because they may have a bed bug infestation at home of which they are not aware.

7. **Should the Health Department be contacted if bed bugs are found at school?** No. Bed bug infestations are not considered a contagious or infectious health issue. The LAUSD pest management department personnel are trained and informed about bed bugs and are fully capable of resolving bed bug problems.

8. **Should people leave a classroom if bed bugs are discovered there?** If five or more bed bugs emerge from or fall out of a student's belongings, the classroom could be temporarily cleared until the situation

is rectified. This can be accomplished quickly by vacuuming up the insects. Call the District's Pest Management department for help.

It is important that bed bug situations be handled professionally with diplomacy, tact, and discreetness.




PARENT INFORMATION

Ways to Prevent Bed Bugs in the Home:

- Encasing mattresses and box springs with bed bug—excluding covers
- Vacuuming, steaming, laundering, and disposing of infested items, including mattresses
- Methods to prevent bed bug infestation (e.g., avoiding the purchase of used mattresses and box springs)

If Bed Bugs are Discovered in Your Home:

- Those who choose to treat their bed bug infestation with insecticides should seek the services of a certified exterminator who uses an integrated pest management approach to avoid pesticide misuse. Those applying insecticides should follow product instructions for safe and appropriate use. Insecticide labels that are easy to read and understand can also help prevent illnesses associated with bed bug control.
- Households with bed bugs should take precautions to prevent transporting bed bugs to schools, daycares, or other facilities.
- Laundering is a highly effective bed bug control method. The heat in the clothes dryer is extremely effective at killing bed bugs and eggs.
- Wash and dry on the highest heat the fabric can stand for 60 minutes.
- Clothing to be worn outside of the home, including coats and backpacks, should be washed and dried in a hot dryer for at least 20 minutes then placed in a tightly sealed container such as a plastic bin until just before the child exits the home.
- Clothing, linens, and other items that cannot be washed - dry on high heat for 20-30 minutes.

BITES: ANIMAL, HUMAN & INSECT

ANIMAL BITES:

1. **What circumstances would students have bites at school?** There are many different circumstances in which students may come to school with bites. Animal bites are common, with dog bites account for 85% to 90% of bite wounds. Students may, unfortunately, be bitten by a pet at home or school. Sometimes, students show up to school after recently being bitten by pets or stray animals and are seen in the health office for first aid.

2. **What are significant symptoms associated with bites?** Bites that penetrate the skin from animals or can easily become infected. If there is an open wound, it is important to clean it with soap and water. Students may experience pain/discomfort surrounding the bite area so that ice would help with any pain and swelling. Anytime an animal bite has broken the skin, it is recommended that the person seek medical attention.

3. **How does infection with bites occur?** Animal bites present a substantial risk of infection. The rate of infection after dog bites is 5% to 20%. After cat bites, the rate of infection is as high as 80%. The longer the animal's mouth germs stay in the wound, the greater the potential of infection that will need antibiotics. Some wounds require preventive antibiotics.

4. **Is there a treatment for bites?** Provide first aid to the student who was bitten by washing any broken skin with soap and water and applying a cold compress to any bruising. At the school site, bandages can be placed over the bite site to avoid unnecessary bacteria from entering the wound or to prevent the student from scratching the area. Anytime an animal bite has broken the skin, it is recommended the person seek medical attention.

5. **What are the circumstances in which bites could be significant?** Consequences from an **animal bite** could be infection, transmission of diseases, or foreign objects embedded in the wound. It is important to notify the parent/guardian of any unusual symptoms present so that the parent may seek medical attention. The situation in which the animal bite occurred should be evaluated for the possibility transmission of rabies. Although any mammal bite can transmit rabies, bites of some wild animals (e.g., bats, raccoons, skunks, foxes, coyotes, bobcats) and some stray and unvaccinated pet dogs and cats are of greatest concern for transmitting the rabies virus. The virus spreads from a rabies infected animal's saliva into the bite site. Rabies is usually transmitted by the bite of wild animals. However, the virus can be spread by unimmunized pets and, in rare cases, immunized pets that have been infected with the rabies virus. The possibility that an animal is infected with rabies is greatest when the animal is unimmunized, and the bite was unprovoked. If a pet or wild animal bites and breaks the skin, the situation requires urgent medical attention.

6. **Exclusion** No, unless the bite caused broken skin or prolonged bleeding, which may require treatment by a health care professional. Exclusion may also be necessary if the student who was bitten or the student who bit another is unable to participate and staff members determine they cannot care for the student without compromising their ability to care for the health and safety of the other students in the group. Ensure proper notification/communication with the parent/guardian of what symptoms are present if there is concern that the bite may be infected.

7. **Readmission:** Yes, when the student is able to participate and staff members determine they can care for the student without compromising their ability to care for the health and safety of the other students in the group. The student that was bitten may return to school if there is no sign of infection or significant symptoms are present.

8. **Contacts and reporting:** It is important to collect information as soon as possible about the animal or human bite incident to decide on the medical management of the bite victim. It is important to ask several clarifying questions regarding the bite incident and description of the biting animal or circumstance in which one person bit another. In an animal bite, it is necessary to identify the implicated animal and its current health status. The site for completing an animal bite reporting form is: https://admin.publichealth.lacounty.gov/phcommon/public/bite/biteaddform.cfm?ou=ph&unit=vet&prog=dcp.

HUMAN BITES:

1. **What circumstances would students have bites at school?** Biting is very common among young children but usually does not lead to serious infectious disease issues. Biting may occur when a child is excited, frustrated, or angry. See if future biting situations can be prevented by identifying what may cause these behaviors and avoiding them, distracting the child before biting occurs, or offering alternative activities. Suggest the child use words to express frustration or anger. Offer a harmless, vigorous physical activity the child can do when frustrated or angry. If the biting behavior of a child is repetitive despite 3 or 4 weeks of using these suggested measures, consider referring the parent for additional professional help to develop an effective management plan.

2. **What are significant symptoms associated with bites?** Bites that penetrate the skin from other humans can easily become infected. If there is an open wound, it is important to clean it with soap and water. Students may experience pain/discomfort surrounding the bite area so that ice would help with any pain and swelling.

3. **How does infection with bites occur?** Human bites present a substantial risk of infection. Anytime a human bite has broken the skin, it is recommended the person seek medical attention. Blood-borne diseases could be a concern if the biter breaks the skin and blood is drawn into the biter's mouth or if the biter has bleeding gums or mouth sores, which transfers germs to the bitten person.

4. **Is there a treatment for bites?** Provide first aid to the student who was bitten by washing any broken skin and applying a cold compress to any bruising. At the school site, bandages can be placed over the bite site to avoid unnecessary bacteria from entering the wound or to prevent the student from scratching the area. Recommend a pediatric health professional visit if the skin is broken because, in some cases, preventive antibiotics may be indicated.

5. **What are the circumstances in which bites could be significant?** It is important to notify the parent/guardian of any unusual symptoms present so that the parent may seek medical attention. It would also be necessary to notify the parent of the "biter". Blood-borne diseases could be a concern if the biter breaks the skin and blood is drawn into the biter's mouth or if the biter has bleeding gums or mouth sores, which transfers germs to the bitten person.

6. **Exclusion:** No, unless the bite caused broken skin or prolonged bleeding, which may require treatment by a health care professional. Exclusion may also be necessary if the student who was bitten or the student who bit another is unable to participate and staff members determine they cannot care for the student without compromising their ability to care for the health and safety of the other students in the group. Ensure proper notification/communication with the parent/guardian of what symptoms are present if there is concern that the bite may be infected.

7. **Readmission:** Yes, when the student is able to participate and staff members determine they can care for the student without compromising their ability to care for the health and safety of the other students in the group. The student that was bitten may return to school if there is no sign of infection or significant symptoms are present.

INSECT BITES:

1. **What circumstances would students have bites at school?** There are many different circumstances in which students may come to school with insect bites. It is common for students to get insect bites at home or school. Sometimes, students show up to school after recently being bitten by insects and are seen in the health office for first aid.

2. **What are significant symptoms associated with bites?** Students may experience pain/discomfort surrounding the bite area so that ice would help with any pain and swelling. If the bite is from an insect or bee, it is important to watch the student for any signs of allergic reaction and to be prepared to use an epinephrine pen if needed.

3. **How does infection with bites occur?** An insect bite can penetrate the skin, allowing bacteria to enter. A common symptom of insect bites is a small, itchy lump. If a person scratches this lump, it may break the skin. This can allow bacteria from their hand to enter the bite, leading to an infection. A person should seek medical help from a doctor if their insect bite becomes infected and antibiotics may be required.

4. **Is there a treatment for bites?** Provide first aid to the student who was bitten by washing the area and placing a cold compress on the insect bite. Bandages can be placed over the bite site to avoid unnecessary bacteria from entering the wound or to prevent the student from scratching the area.

5. **What are the circumstances in which bites could be significant?** Some people can have an allergic reaction to an insect bite. If this happens, a person should seek medical help. The main sign of an allergic reaction is swelling of the skin around the bite that lasts longer than 24 hours. Insect bites can cause several common infections like impetigo, cellulitis, lymphangitis, or Lyme Disease.

6. **Exclusion:** No, unless the bite caused the student to be unable to participate and staff members determine they cannot care for the student without compromising their ability to care for the health and safety of the other students in the group.

7. **Readmission:** Yes, when the student is able to participate and staff members determine they can care for the student without compromising their ability to care for the health and safety of the other students in the group. The student that was bitten may return to school if there is no sign of infection or significant symptoms are present.

CHICKENPOX (VARICELLA-ZOSTER INFECTIONS)

1. **What is chickenpox?** Chickenpox is an infectious disease caused by the varicella-zoster virus that results in a rash, most often occurring in persons less than 15 years old.

2. **What are the signs and symptoms of chickenpox?** The most obvious sign of chickenpox infection is the development of a blister-like rash. This rash begins with small, red spots that develop into blisters (vesicles) after a few hours. It first appears on the trunk and face but can spread over the entire body. These blisters will become pus-filled after 3-4 days and then develop into scabs. Fever, itching, cough, runny nose, and/or headache commonly accompany this rash.

3. **Incubation period:** Usually 14 – 16 days.

4. **Contagious period:** From 1 – 2 days before the rash appears until after the last crop of vesicles. A person no longer spreads the virus when all blisters have scabs, and no new blisters form. Although uncommon, a previously immunized person can have a mild form of chickenpox, which is contagious.

5. **How does infection with chickenpox occur?** Chickenpox is a highly infectious virus; it spreads from person to person by direct contact with an infected person or breathing in air containing germs released when the infected person coughs or sneezes.

6. **How can infection with chickenpox be prevented?** Chickenpox can be prevented with a vaccination required by law for school admission. Other methods, such as varicella-zoster immune globulin (VZIG), can prevent chickenpox in immunocompromised children after exposure. VZIG must be given very early after exposure to be effective.

7. **Is there a treatment for chickenpox?** Antiviral medication and treatment should be considered for individuals at increased risk for moderate to severe disease (e.g., >12 years old, chronic skin or lung infections, immunocompromised, etc.). Antivirals are most effective when administered early in the disease. Children who have chickenpox ***should not*** be given aspirin, as it can lead to serious liver disease (Reye's syndrome).

8. **What are the circumstances in which chickenpox could be significant?** One in ten children has a complication that is serious enough to visit a health care provider. Complications include infected skin lesions, other infections (such as pneumonia), dehydration from vomiting or diarrhea, and asthma exacerbation. Adults, infants, adolescents, and people with weak immune systems are more likely to have serious illnesses with complications. Initial chickenpox infections in adults can be extremely serious and may result in death.

9. **Can you get chickenpox more than once?** Yes, but it is very rare. Cases are generally mild, with less fever and fewer blisters than the first time.

10. **Exclusion:** Yes – routine exclusion of infected children from school is warranted until they are *no longer contagious*.

11. **Readmission:** When all blisters have scabs, (usually 6 days after the start of the rash in healthy individuals), or, in immunized children who have a mild infection with no crusts, once no new red bumps have appeared for at least 24 hours.

12. **Contacts and reporting:** Informational letters are to be sent to the parent/guardian of all students and employees when chickenpox is first identified in the school each new semester. (Attachment A [English] or Anexo A-1 [Spanish], "Chickenpox Student Notification Letter," and Attachment B, "Chickenpox *Employee* Notification Letter," in BUL-1937.4, *Reporting Communicable Diseases*, dated December 1, 2025).

COMMON COLD

1. **What is the common cold?** The common cold is a highly contagious viral infection of the upper respiratory tract that increases in prevalence during the fall and winter.

2. **What are the signs and symptoms of the common cold?** Symptoms of the common cold often include runny nose, sneezing, sore throat, cough, and headache. Fever is usually slight but can climb to 102 degrees Fahrenheit in infants and young children. While nasal discharge is usually watery and clear at the onset, it can become colored and thick after a few days. This does not correlate with bacterial infections, although the common cold can occasionally lead to ear or sinus infections that require antibiotic treatment. High fever, significantly swollen glands, severe facial pain in the sinuses, and a cough that produces mucus may indicate a complication or more serious illness requiring a doctor's attention.

3. **Incubation period:** 2 – 14 days.

4. **Contagious period:** Usually a few days before signs and symptoms appear and while clear runny nasal secretions are present. Viral shedding is most abundant in the first few days of infection and usually ceases within 7 – 10 days.

5. **How does infection with the common cold occur?** The common cold is passed from person to person through direct or close contact with mouth and nose secretions, including inhalation of tiny droplets containing the virus. Transmission can also happen indirectly when a healthy person touches an object or surface soiled by nasal or oral discharge from the infected person and then touches his or her eyes or nose.

6. **How can infection with the common cold be prevented?** The best prevention methods are general hygiene measures, such as frequent hand washing, covering the mouth and nose with tissues when coughing or sneezing, and properly disposing of tissues. If possible, one should avoid close, prolonged exposure to persons who have colds.

7. **Is there a treatment for a common cold?** Only the symptoms can be treated, there is no cure or vaccine for the common cold at this time. Children who have a viral infection ***should not*** be given aspirin, for they run the risk of developing a rare but serious illness called Reye's syndrome.

8. **Exclusion: Generally, none** for children with the common cold, unless they meet other exclusion criteria (see "General Exclusion Criteria for Schools" page 6).

9. **Readmission:** Upon recovery, by the school principal or principal's designee.

CONJUNCTIVITIS

1. **What is conjunctivitis?** Conjunctivitis is a condition in which the conjunctiva, the clear membrane that covers the eye, becomes inflamed. Conjunctivitis is caused by bacteria, viruses, chemicals, and allergies. Infectious conjunctivitis is commonly known as "pinkeye."

2. **What are the signs and symptoms of conjunctivitis?** Signs and symptoms vary according to the kind of conjunctivitis:
   - **Bacterial Conjunctivitis** is characterized by redness, itching, and eye pain, with more than a tiny amount of green or yellow discharge containing mucus and or pus. It may affect one or both eyes.
   - **Viral Conjunctivitis** is characterized by redness, watery eyes, and sensitivity to light and may affect only one eye or both eyes.
   - **Allergic Conjunctivitis** is characterized by itching, redness, and excessive tearing usually of both eyes.
   - **Chemical Conjunctivitis** is characterized by red, watery eyes, especially after swimming in chlorinated water.

3. **Incubation period:** Depends on the type of conjunctivitis.
   - **Bacterial Conjunctivitis**: The incubation period is unknown because the bacteria that cause it are commonly present in most individuals and do not usually cause infection.
   - **Viral Conjunctivitis**: Sometimes occurs early in the course of a viral respiratory tract disease that has other signs or symptoms.
   - **Allergic Conjunctivitis**: Occurs in response to contact with the agent that causes the allergic reaction. The reaction may be immediate or delayed for many hours or days after the contact.
   - **Chemical Conjunctivitis**: Usually appears shortly after contact with the irritating substance.

4. **Contagious period:** Allergic and chemical conjunctivitis are not contagious. Bacterial conjunctivitis contagious period ends when the course of medication is started. Viral conjunctivitis contagious period continues while the signs or symptoms are present.

5. **How does infection with conjunctivitis occur?** Conjunctivitis caused by bacteria or viruses can be passed from an infected person to a healthy person through direct or indirect contact with articles, such as those used for eye makeup, that are freshly soiled with infectious discharge. Conjunctivitis caused by an allergy is not contagious.

6. **How can infection with conjunctivitis be prevented?** Strict personal hygiene, careful hand washing, use of separate towels, prompt treatment of bacterial infected eyes, and avoiding contagious individuals can help prevent the spread of conjunctivitis.

7. **Is there a treatment for conjunctivitis?** Bacterial conjunctivitis can be treated with antibiotics, usually given as eye drops. The family should consult a health professional for diagnosis and possible treatment. The role of antibiotics in preventing the spread of bacterial conjunctivitis is unclear. Antibiotics shorten the course of pinkeye only minimally, if at all. Most children with pinkeye get better after 5 or 6 days without antibiotics.

8. **What are the circumstances in which conjunctivitis could be significant?** If left untreated, conjunctivitis can create serious complications, such as infection in the cornea, lids, and tear ducts. One type of conjunctivitis, caused by the bacterium *Chlamydia trachomatis*, can lead to blindness.

9. **Exclusion:** For most instances of conjunctivitis, exclusion is not required. If the student is experiencing significant symptoms, such as behavioral changes, fever, or significant mucus drainage, it is recommended they seek medical evaluation and treatment. The student should be excluded if their symptoms meet other exclusion criteria or if there is a recommendation from the local health department or the student's health professional.

10. **Readmission:** When exclusion criteria are resolved and the child is able to participate in the educational program. After exclusion for confirmed **bacterial** conjunctivitis, the child may return after treatment has begun with antibiotic eye drops or ointment.

COVID-19*

*** These guidelines are subject to change based on guidance from federal, state, and local health authorities.**

1. **What is COVID-19?** COVID-19 is an infectious disease caused by the SARS-CoV-2 virus. Most people infected with the virus will experience mild to moderate respiratory illness and recover without requiring special treatment. However, some will become seriously ill and require medical attention. Older people and those with certain underlying medical conditions like cardiovascular disease, diabetes, chronic respiratory disease, or cancer are more likely to develop serious illness.

2. **What are the signs and symptoms of COVID-19?** COVID-19 affects different people in different ways. Infected people have had a wide range of symptoms reported—from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus.
   Children: Symptoms consistent with possible COVID-19 infection in children include fever, new cough (different from baseline), vomiting or any new onset diarrhea, and pinkeye.
   Adults: Symptoms consistent with possible COVID-19 in adults include fever or feeling feverish (chills, sweating); cough; shortness of breath; new loss of taste or smell; fatigue; runny or stuffy nose; muscle or body aches; headache; sore throat; nausea or vomiting; diarrhea.

3. **Incubation period:** Viruses are constantly changing, which leads to new strains called "variants". Different COVID-19 variants can have different incubation periods. The incubation period for COVID-19 is, on average, 2 to 14 days, with a mean of 2 to 4 days.

4. **Contagious period:** From 2 days before signs or symptoms appear until 10 days after the onset of symptoms. Vaccination may shorten the contagious period. Regardless of symptoms, those who test positive are advised to take precautions for at least 10 days.

5. **How does infection with COVID-19 occur?** COVID-19 is transmitted between people in several ways. Current evidence suggests that the virus spreads mainly between people who are in close contact with each other, for example, at a conversational distance. The virus can spread when a person with COVID-19 releases respiratory droplets into the air when speaking, singing, coughing, shouting, or exercising. Other people then breathe these droplets or land on their nose, mouth, or eyes. The virus also spreads by touching a surface with droplets and then touching your eyes, nose, or mouth, but this is less common. There are certain places where COVID-19 spreads more easily: in closed spaces with poor airflow; in crowded spaces with many people nearby; and close contact settings especially where people are talking or breathing close together.

6. **How can infection with COVID-19 be prevented?** It is recommended that people be vaccinated and get boosted when eligible. Those who are at high risk for serious illness are encouraged to wear a mask in indoor public places. To improve ventilation in public spaces, you may open windows and doors, use fans and portable air cleaners, run heating and air, and upgrade filters regularly. Choose outdoor spaces for social and fitness activities when possible. Keeping distance from others (about 6 feet) for social distancing with people you do not live with can assist in preventing infection.

7. **Is there a treatment for COVID-19?** If someone is infected with COVID-19 and at higher risk of getting very sick, they can get medicines that treat COVID-19 and help keep them out of the hospital. Treatment for those of high risk should be recommended to get treatment as soon as possible. Oral medicines Paxlovid and molnupiravir must be taken within 5 days of the start of symptoms.

8. **What are the circumstances in which COVID-19 could be significant?** Most children who become infected with the COVID-19 virus have only a mild illness. But in rare cases, some children go on to develop MIS-C (Multisystem inflammatory syndrome in children). With MIS-C, some organs and tissues, such as the heart, lungs, blood vessels, kidneys, digestive system, brain, skin, or eyes, become severely inflamed. The signs and symptoms of MIS-C depend on which areas of the body are affected. Most children who develop MIS-C eventually get better with medical care. But some kids rapidly get worse, to the point where their lives are at risk. It is recommended that any children experiencing symptoms of MIS-C should seek medical attention immediately.

9. **Exclusion:** Yes, if the child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group. The student should be excluded if they meet other exclusion criteria (the child has fever and behavior change or fever with other signs or symptoms of respiratory illness-like cough, sore throat, sneeze, or runny nose).

10. **Readmission**: When exclusion criteria are resolved, fever has been absent for 24 hours without fever-reducing medicines, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

11. **Contacts and reporting:** The Communicable Disease (CD) Desk at District Nursing Services Branch reports all clusters of acute respiratory illnesses identified at LAUSD schools. Please contact the CD Desk when a school site is experiencing one of the following:
    - A minimum of 5 cases or 20% of the group *in a linked group (e.g., classroom, sports team)* with acute respiratory illness within a 7-day period.
    - At least 10% of average daily attendance are absent or showing symptoms of acute respiratory illness, with a minimum of 5 individuals ill, *within a 3-day span across the facility (e.g., entire school)*.

CROUP

1. **What is Croup?** Croup is a disease that causes swelling in the airways and problems breathing. Children with croup often have a high-pitched “creaking” or whistling sound when breathing in. This is called stridor.

2. **What are the signs and symptoms of Croup?** Symptoms of croup are not always the same. The symptoms can change as the disease moves from the nose to the lungs. Common symptoms of croup are runny nose, congestion, cough that turns into a "seal's bark", laryngitis (losing his or her voice), fever, and stridor.

3. **Incubation and Contagious periods:** Symptoms of viral croup will typically surface within two- or three-days following exposure to one of the viruses that cause it (with an incubation period of 24 to 72 hours). This is also the time when a child is at their most contagious and at high risk of infecting others.

4. **How does infection with Croup occur?** Croup is commonly caused by a virus. It is sometimes, but rarely, caused by bacteria, allergies, or reflux from the stomach. Croup is spread through direct contact with a person or fluids from another person with the disease. The infection starts in the nose and throat and moves into the lungs. Swelling affects the area around the voice box (larynx) and into the windpipe (trachea). Younger children are more affected by croup because their airways are smaller. Therefore, a small amount of swelling can make breathing hard for a child.

5. **How can infection with Croup be prevented?** Croup is spread similarly to the common cold, so it is difficult to prevent. Good hygiene and respiratory etiquette is the main defense against croup, such as regularly washing hands and cleaning surfaces.

6. **Is there a treatment for Croup?** A single dose of an oral corticosteroid medication called dexamethasone or prednisolone will usually also be prescribed to help reduce the swelling in the throat. If the child has breathing problems, they may need hospital treatment, such as taking adrenaline and oxygen through a mask.

7. **What are the circumstances in which Croup could be significant?** The danger of croup with stridor is that sometimes the airway may swell so much that your child may barely be able to breathe. In the most severe cases, the student will not be getting enough oxygen into their blood. Some children with severe croup do need medical evaluation/treatment to improve their breathing. They may need a breathing treatment (racemic epinephrine) to calm their breathing and a period of observation to ensure symptoms do not recur. There are few children who are admitted to the hospital for recurrent treatment and observation, and the most severe cases may need additional breathing support.

8. **Exclusion:** No, unless the student exhibits respiratory distress (Call EMS [911]), the students meets other exclusion criteria or the student is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group.

9. **Readmission:** Yes, when all the following criteria are met: When exclusion criteria are resolved, the student is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other students in the group.

ENTEROVIRUS (non-Polio)

1. **What is a Non-Polio Enterovirus?** Non-polio enteroviruses are common viruses. Infants, children, and teenagers are more likely to get infected and become sick because they do not yet have immunity (protection) from previous exposures to viruses. Most people infected with non-polio enteroviruses do not get sick or may have mild illnesses, like the common cold. However, some people can get extremely sick and have an infection in their heart or brain or even become paralyzed (Enterovirus D68 has been known to cause paralysis). Infants and people with weakened immune systems have a greater chance of having these complications. You can get infected with non-polio enteroviruses by having close contact with an infected person. You can also get infected by touching objects or surfaces with the virus and then touching your mouth, nose, or eyes.

2. **What causes the Non-Polio Enterovirus?** Non-polio enteroviruses can be found in an infected person's feces (stool), eyes, nose, mouth secretions (such as saliva, nasal mucus, or sputum), or blister fluid. You can get exposed to the virus by having close contact, such as touching or shaking hands with an infected person, touching objects or surfaces that have the virus on them, changing diapers of an infected person, or drinking water that has the virus in it. If you touch your eyes, nose, or mouth before washing your hands, you can get infected with the virus and become sick.

3. **Incubation period:** 2 - 7 days.

4. **Contagious period:** Non-polio enterovirus can be shed (passed from a person's body into the environment) in your stool for several weeks or longer after you have been infected. The virus can be shed from your respiratory tract for 1 to 3 weeks or less. Infected people can shed the virus even if they do not have symptoms.

5. **How is infection with enteroviruses diagnosed?** Non-polio enteroviruses can be detected in stool or rectal swabs and respiratory specimens (including from the throat). Depending on the symptoms, several specimen types can be collected for testing by the health care provider. A positive laboratory test for non-polio enteroviruses from certain specimens, such as rectal or respiratory swabs, does not necessarily mean the virus is the cause of infection (due to being shed for weeks).

6. **How can infection be prevented?** Since many infected people do not have symptoms, it is difficult to prevent non-polio enteroviruses from spreading. You can help protect yourself and others from non-polio enterovirus infections by:
   - Washing your hands often with soap and water, especially after using the toilet and changing diapers,
   - Avoiding close contact, such as touching and shaking hands, with people who are sick and
   - Cleaning and disinfecting frequently touched surfaces.

7. **Is there a treatment for Non-Polio Enteroviruses?** There is no specific treatment for non-polio enterovirus infection. People with mild illness caused by non-polio enterovirus infection typically only need symptom treatment. They usually recover completely. However, some illnesses caused by non-polio enteroviruses can be severe enough to require hospitalization.

8. **Exclusion:** Yes, if the person meets other exclusion criteria (see “General Exclusion Criteria for Schools” page 6).

9. **Readmission:** Upon recovery, by the school principal or principal's designee.

10. **Contacts and reporting:** Nonreportable, but if your school has a significant number of confirmed cases (over 5 in one class or 10% of the school population), call the District Nursing Services Branch CD Desk.

FEVERS

1. **What are fevers?** Fever is an elevation of the normal body temperature. While there are several definitions of fever, for the purpose of evaluating a student in school, fever is defined as temperature of ≥ 100.4°F (38°C) oral, temporal, or ear. Fever is an indication of the body's response to something but is neither a disease nor a severe problem by itself. These temperature elevations are not necessarily an indication of a significant health problem. Children's temperatures may be elevated for a variety of reasons, most of which do not indicate serious illness.

2. **What causes fevers?** Fever is most commonly caused by the body's response to a viral or bacterial infection, but it can have causes other than infection, such as juvenile idiopathic arthritis, a reaction to a vaccine or medication, or cancer.

3. **What are some considerations regarding fevers?** Normal body temperature may change during any given day. It is usually highest in the evening. Other factors that may affect body temperature are a woman's menstrual cycle (it could go up by 1 degree F or more), physical activity, strong emotions, eating, heavy clothing, medicines, high room temperature, and high humidity can all increase body temperature.

4. **Does fever mean a child is contagious?** Children with fever are not always contagious. Noncontagious causes of fever include urinary tract infections, ear infections, and causes unrelated to infections. The most common cause of fever is a viral upper respiratory infection (the common cold). Although the common cold is contagious, it is not particularly harmful to others. Some children have a fever and never develop other symptoms, and the fever resolves by itself. Many infections cause a child to be contagious for several days before a fever develops. Some infections cause a child to remain contagious long after the fever has resolved. Finally, many children spread germs without ever developing a fever or other symptoms.

5. **Is fever harmful to the child?** No. Most (virtually all) fevers that occur because of infectious diseases are not harmful. The very high body temperatures in heatstroke are harmful. Children should never be left unattended in a car because the temperature can rise quickly and cause heatstroke (hot, dry, red skin with lethargy) and even death in a young child. Exercising in excessively hot weather or in overheated indoor rooms can also be harmful. Children with fever are usually less active. Children with fever need to drink more to avoid dehydration. Dehydration may occur because fever depletes body fluids, which should be replaced with increased fluid intake. Some young children with fever may have a brief seizure called a *febrile seizure*. Most brief seizures associated with fever last less than 15 minutes, occur in children younger than 6 years, and are not harmful. They are frightening to witness but do not result in any kind of brain damage. However, a child who has experienced a seizure with fever for the first time should be referred to a pediatric health professional for evaluation. Referral to a pediatric health professional is not needed only if the child's seizure fits the pattern of a previously identified febrile seizure disorder for that child and the program has been taught by a health professional how to manage a febrile seizure for that child. Fever is one way the body may respond to an infection. When fever develops, all the infection-fighting mechanisms tend to speed up and can help the body fight the infection. Children may have high elevations in body temperature and appear relatively well. Therefore, fever is not a good indication of severity of illness. Behavior is a much more reliable indicator of the significance of illness than the presence and height of fever. However, high elevations in body temperatures can

sometimes affect behavior. Children who appear to be moderately ill with a fever should be referred for a medical evaluation.

6. **Is there a treatment for fevers?** Treating the fever is not necessary unless the child is uncomfortable. Evidence suggests fever helps the body fight infection. Acetaminophen (e.g., Tylenol) or ibuprofen (e.g., Advil, Motrin) may be considered for the child's comfort if the child feels ill. Generally, there is no rush to reduce a child's temperature. Aspirin should never be administered to children with fever because of the potential risk of Reye syndrome. Reye syndrome is a serious complication associated with the use of aspirin in someone infected with a viral illness. There is no need to cool the child to try to bring down an elevated body temperature. A known exception is if the child's elevated temperature is not a fever but the result of exposure to extreme heat, often associated with vigorous exercise or an excessively hot environment (heat exhaustion or heatstroke); such instances are medical emergencies that require immediate first aid and health professional care. Infants younger than 4 months with an unexplained fever should be evaluated by a pediatric health professional. Any infant younger than 2 months with a temperature above 100.4 °F (38.0 °C) should get medical attention immediately—within an hour if possible. The fever is not harmful; however, the illness causing it may be serious in infants younger than 2 months.

7. **Exclusion:** Fever that is associated with behavior change or other signs of illness or other conditions requires exclusion. The signs of illness are anything (other than the fever) that indicates the child's condition is different from what is usual when the child is healthy.

8. **Readmission:** The student may be readmitted upon recovery by school personnel when exclusion criteria are resolved, the child is able to participate and have been fever-free for at least 24 hours without fever-reducing medication.

9. **Contacts and reporting:** No reporting is required as there needs to be other symptoms identified to be indicative of an outbreak of a particular disease.

FIFTH DISEASE

1. **What is Fifth disease?** Fifth disease is a mild rash illness caused by human parvovirus B19 that occurs most commonly in children. It is a common viral infection occurring 4 to 14 days (up to 21 days) after the start of the viral infection.

2. **What are the signs and symptoms of Fifth disease?** Fever, headache, muscle aches. Uncommon symptoms are itchiness, cough, diarrhea or vomiting, runny nose, and joint aches. Red "slapped-cheek" rash appears 4 to 14 Red slapped-cheek rash appears 4 to 14 days (up to 21 days) after these signs or symptoms. This characteristic rash is followed shortly by a lacelike appearing rash proceeding from trunk to arms, buttocks, and thighs. Rash may disappear and reappear after exposure to heat for weeks; once rash appears, the child is no longer contagious and usually does not feel ill.

3. **Incubation period:** From 4 – 14 days but can be as long as 21 days.

4. **Contagious period:** Healthy individuals are contagious until the rash appears.

5. **How does infection with Fifth disease occur?** Respiratory (droplet) route: Contact with large droplets that form when a child talks, coughs, or sneezes. These droplets can land on or be rubbed into the eyes, nose, or mouth. The droplets do not stay in the air; they usually travel no more than 3 feet and fall onto the ground. Exposure to blood or blood products or a baby can be infected before birth from infection of a pregnant mother (very rare).

6. **How can infection with Fifth disease be prevented?** There is currently no vaccine or medicine that prevents Fifth disease. Frequent hand washing is recommended as a practical and effective method to decrease the chance of becoming infected. Sanitation of contaminated items. Disposal of tissues containing nose and throat secretions. Prevent contact with respiratory secretions. Teach children and educators to cover their noses and mouths when sneezing or coughing with a disposable facial tissue, if possible, or with an upper sleeve or elbow if no facial tissue is available in time. Teach everyone to remove any mucus or debris on skin or other surfaces and perform hand hygiene right after using facial tissues or having contact with mucus to prevent the spread of disease by contaminated hands.

7. **Is there a treatment for Fifth disease?** Treatment of symptoms such as fever, pain, or itching is usually all that is needed unless a more serious condition develops.

8. **Does keeping an infected child home from school help prevent the spread of Fifth disease?** Excluding persons with fifth disease from work, childcare centers, or schools is not likely to prevent the spread of the virus since people are contagious before they develop the rash and are no longer contagious once the rash appears.

9. **What are the circumstances in which Fifth disease could be significant?** Fifth disease is usually a mild illness that resolves on its own among children and adults who are otherwise healthy. However, Fifth disease may cause a serious illness in persons with sickle-cell disease or similar types of chronic anemia. Persons with weak immune systems (due to conditions like leukemia, cancer, organ transplants, HIV, etc.) are also at risk for serious illness due to Fifth disease infection and should seek medical care

if exposed. Pregnant women who may be exposed to Fifth disease should consult their health professional about their immune status and risk of infection.

10. **Exclusion: Generally, none** unless the child has sickle cell disease or compromised immune system or they meet other exclusion criteria (see "General Exclusion Criteria for Schools" page 6).

11. **Readmission:** When exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

12. **Contacts and reporting:** Not reportable. Although Fifth Disease is benign for most individuals, there are some precautions for pregnant women. An informational letter should be sent to parent/guardian/ teachers of all students in the affected classroom (Attachment H [English] or Anexo H-1 [Spanish], "Fifth Disease Notification Letter," in BUL-1937.4, *Reporting Communicable Diseases*) with each identified case.

FOODBORNE ILLNESS

1. **What is foodborne illness?** Foodborne illness, or food poisoning, is caused by consuming contaminated food or beverages. Many different microbes can contaminate food. More than 250 different foodborne illnesses have been described. Most of these diseases are infectious and caused by a variety of bacteria, viruses, and parasites. Harmful toxins and chemicals can also contaminate food, such as those found in poisonous mushrooms.

2. **What are the symptoms of a foodborne illness?** Symptoms vary based on the cause of food poisoning; hence, there is no one "syndrome" caused by foodborne illness. In all types of foodborne disease, the microbe or toxin enters the body through the gastrointestinal tract and often causes nausea, vomiting, abdominal cramps, and diarrhea.

3. **Incubation period:** May begin within hours to days of food ingestion, depending on the organism.

4. **Contagious period:** Varies according to the organism.

5. **What are the most common microbes that cause foodborne illness?** Bacteria causing foodborne illness include *Salmonella, E. Coli, Shigella, Clostridium botulinum*, and others. Viruses include *hepatitis A* and *Calicivirus* or *Norwalk-like virus*, while parasites like *Giardia lamblia* and *Cryptosporidia* can also cause foodborne diseases. It is rarely possible to say which microbe is likely to be causing a given illness unless laboratory tests are done to identify the microbe or the illness is part of a recognized outbreak.

6. **How can foodborne illness be prevented?** Thoroughly cook all food (i.e., meat, poultry, eggs). Avoid cross-contamination by washing hands, utensils, and cutting boards after contact with raw meat or poultry. Refrigerate prepared foods and leftovers. Protect food against contamination by washing hands and rinsing vegetables.

7. **Is there treatment for foodborne illnesses?** There are many different types of foodborne illnesses, and they may require different treatments depending on the symptoms they cause. Fluids and electrolyte replacement are important. Medical attention may be necessary if symptoms are severe. Antibiotics are not always needed.

8. **What are the circumstances in which foodborne illness could be significant?** While some foodborne illnesses are self-limited, others are or can become serious illnesses. Certain strains of *E. Coli* can result in bleeding disorders and kidney failure. Botulism can result in paralysis and death, particularly in infants. Immunocompromised individuals may be at greater risk for severe disease in some cases. All persons suffering from foodborne illness may become dehydrated and possibly septic.

9. **Exclusion:** Yes, if a person is symptomatic or meets other exclusion criteria (see "General Exclusion Criteria for Schools" page 6). In cases of foodborne infections, symptomatic employees (including food handlers) should be immediately referred to their primary care provider for assessment, treatment, and readmission. In cases of some foodborne illnesses such as salmonella or shigella, LACDPH will provide medical clearance for readmission.

10. **Readmission:** When the student has clearance from their medical provider or the local health department and the child is able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

11. **Contacts and reporting:** Many foodborne illness pathogens and commercial food products suspected of causing illness are reportable to the Los Angeles County Department of Public Health. Call the CD Desk if there is suspicion of a foodborne illness on campus.

HAND, FOOT, AND MOUTH DISEASE

1. **What is hand, foot, and mouth disease?** Hand, foot, and mouth disease (HFMD) is a common illness caused by a virus (most commonly Enterovirus 71 and Coxsackievirus A16) in infants and children. It is rarely serious. Although it mainly occurs in children under 10 years old, adults may also be at risk. HFMD is not to be confused with foot-and-mouth disease of cattle, sheep, and swine, which is unrelated.

2. **What are the signs and symptoms of HFMD?** HFMD begins with a mild fever, poor appetite, a sore throat, and general signs of a "cold." A few days after the fever begins, sores develop in the mouth. The sores appear as red spots that turn into blisters on the tongue, gums, and inside of the cheeks. A skin rash may also occur, which develops over 1-2 days and is characterized by flat or red raised spots that may blister. The rash does not itch and usually occurs on the palms of the hands and soles of the feet. Nearly all patients recover without medical treatment in 7 - 10 days.

3. **Incubation period:** 3 – 6 days.

4. **Contagious period:** The virus may be shed for several weeks to months after the infection starts; respiratory shedding of the virus is usually limited to 1 to 3 weeks. A person is most contagious during the first week of the illness.

5. **How does infection with HFMD occur?** HFMD is moderately contagious, and infection is spread from person to person by direct contact with nose and throat discharge or the stool of an infected person. HFMD is not transmitted to or from pets or other animals.

6. **How can infection with HFMD be prevented?** Frequent hand washing, especially after diaper changes, and disinfecting contaminated surfaces with household cleaners are the best mitigation strategies. Prevent contact with respiratory secretions. Teach children and educators to cover their noses and mouths when sneezing or coughing with a disposable facial tissue, if possible, or with an upper arm sleeve or elbow if no facial tissue is available in time. Teach everyone to remove any mucus or debris on skin or other surfaces and perform hand hygiene right after using facial tissues or having contact with mucus to prevent the spread of disease by contaminated hands. Change or cover clothing with mucus on it. Dispose of facial tissues that contain nasal secretions after each use.

7. **Is there a treatment for HFMD?** HFMD cannot be cured by medication, but treatment is available for symptoms such as fever or pain in the mouth from ulcers.

8. **What are the circumstances in which HFMD could be significant?** Rarely, HFMD may be associated with serious infections such as viral meningitis/encephalitis with fever, headache, stiff neck, or polio-like paralysis, which could require hospitalization.

9. **Exclusion:** No exclusion is required for children with HFMD, **unless** they meet other exclusion criteria (see "General Exclusion Criteria"). Excessive drooling from mouth sores might be a problem that staff members will find difficult to manage for some children with this disease. If they have a fever, symptoms of illness, and/or fluid filled or oozing (wet) lesions, they should be sent home.

10. **Readmission:** When exclusion criteria are resolved and the child is able to participate in the educational program. They may attend school if they are without fever for 24 hours and their sores have dried (scabbed over and no longer fluid filled or oozing).

11. **Contacts and reporting:** Nonreportable. The notification letter (Attachment F [*English/Spanish*], "Hand, Foot, And Mouth Disease Notification Letter," in BUL-1937.4, *Reporting Communicable Diseases*) should be sent to the parent/guardian of students in a classroom with the first incident of two or more identified/confirmed cases each semester. Schools should report when they have 5 or more cases to the CD Desk.

HEAD LICE

1. **What are head lice?** Head lice are parasitic insects called *Pediculus humanus capitis* that must feed on blood to live. Having head lice is common.

2. **What are the signs and symptoms of head lice?** Signs that head lice are present include a tickling feeling of something moving in the hair, itching caused by an allergic reaction to the bites, irritability, and sores on the head from scratching that may become infected. Head lice lay eggs, called nits, that are hard to see and are often confused for dandruff or hair-spray droplets. Once hatched and fully grown, a live louse is about the size of a sesame seed and is tan to grayish-white.

3. **Incubation period:** 6 – 10 days from laying to hatching of eggs.

4. **Contagious period:** Until treated with a chemical that kills lice and viable eggs have been killed or removed.

5. **Who is at risk of getting head lice?** Anyone who comes in close contact with someone who already has head lice or with contaminated clothing and other belongings is at risk for getting head lice. Preschool and elementary-age children are most often infested.

6. **How does infestation with head lice occur?** Infestation with head lice occurs by direct contact with an already infested person, which is common during play at school and home. Infestation can also occur by wearing infested clothing such as hats, scarves, etc., using infested combs or brushes, or lying on a bed or a couch that has been in contact with an infested person. The presence of nits alone does not indicate active infestation.

7. **How can infestation with head lice be prevented?** It is probably impossible to completely prevent head lice infestations. As mentioned above, avoiding contact with an infested person or objects is the best prevention measure. Inspection of children demonstrating symptoms, especially in areas where head lice are prevalent, is also helpful.

8. **Is there a treatment for head lice?** Over-the-counter treatments and prescription drugs are available for treating head lice. Treatment often entails combing out the eggs and casings (nits) attached to the hair shaft with a specialized or fine-toothed comb. It is important to treat the infested person and any infested family members; wash or dry clean all clothing and bed linens; store stuffed animals and comforters in a plastic bag for 2 weeks; clean combs and brushes; and vacuum the floor and furniture.

9. **What are the circumstances in which head lice could be significant?** Head lice rarely pose a serious problem. Sores that occur due to scratching can become infected and a licensed healthcare provider should be consulted.

10. **Exclusion:** Yes**,** when a student has the signs and symptoms of active infestation (the presence of a live louse), the condition **does not warrant immediate exclusion**. A student identified as having head lice shall be excluded at the end of the school day for treatment at home. At the discretion of the school administrator, a child may be sent home for immediate treatment based on the severity (live lice with severe itching) of the condition. A notification letter and informational fact sheet (Attachment D

[English/Spanish], "Head Lice *Student* Exclusion Letter," *and* Attachment E [English] or Anexo E-1 [Spanish], "Head Lice (Pediculosis Capitis) - Fact Sheet," in BUL-1937.4, *Reporting Communicable Diseases*) should be given to the parent/guardian. Inform parents of suspected infestation and have the student avoid any activity that involves the child in head-to-head contact with other children or sharing any headgear until the end of the school day. A lice notification letter may be sent home to the classroom with the first incident of two or more identified cases each semester. Subsequent letters are not necessary unless there is an outbreak as identified by LACDPH.

11. **Readmission:** Students may return to school the next day after appropriate treatment is instituted.

HEPATITIS A, B, AND C

1. **What are hepatitis A, B, and C?** Hepatitis A, B, and C are liver diseases caused by the hepatitis A, B, and C virus, respectively.

2. **What are the signs and symptoms of hepatitis A, B, and C?** All three viruses can cause asymptomatic infection, and adults are more likely to have symptoms than children. Symptoms common to the three viruses are as follows: fatigue, loss of appetite, nausea, vomiting, abdominal discomfort, jaundice (yellowing of the skin and eyes), and dark urine. In addition, hepatitis A is usually more abrupt in onset; hepatitis B may cause joint pains and rash.

3. **Incubation period:**
   Hepatitis A: 15 – 50 days; average 25 – 30 days;
   Hepatitis B: 45 – 160 days; average 90 days;
   Hepatitis C: 14 – 180 days; average 45 days.

4. **Contagious period:**
   Hepatitis A: 2 weeks before the onset of signs and symptoms, infectivity is minimal one week after onset of jaundice;
   Hepatitis B: if the virus is present in the blood of the infected person;
   Hepatitis C: unknown.

5. **How does infection with hepatitis A, B, and C occur?**
   Hepatitis A is found in an infected person's feces and is usually spread from person to person by putting something in the mouth that has been contaminated with the feces of a person with hepatitis A.
   Hepatitis B is found in bodily fluids and blood. It is spread from person to person through unprotected sex, needle sharing, or blood transfusion. It can also be spread from mother to infant.
   Hepatitis C is found in bodily fluids and blood and is usually spread through needle sharing, needle sticks or sharps exposure, and blood transfusions. It can also be passed from a pregnant mother to her baby during birth. It rarely spreads through sexual contact.

6. **How can infection with hepatitis A, B, or C be prevented?**
   Hepatitis A: a vaccine is available for persons 2 years of age and older. Major methods of prevention include general sanitation and personal hygiene. There is an immune globulin for exposed individuals who meet specific criteria.
   Hepatitis B: A vaccine is available for all ages. Other methods of prevention include sanitation, universal precautions, and the use of latex condoms.
   Hepatitis C: There is no vaccine currently available to prevent hepatitis C. Avoidance of needle sharing by injection drug users or people receiving tattoos or body piercing(s) is a helpful preventative measure, as is using latex condoms during sexual contact.
   Note: Students with Hepatitis B, Hepatitis C, or HIV are generally not required to be identified to school personnel. Universal precautions should be taken when handling any blood or body fluids in school settings to acknowledge the risk of exposure to all types of unrecognized diseases.

7. **Is there a treatment for hepatitis A, B, or C?** Treatment is generally supportive. No cure exists currently for hepatitis A or B, but medication for chronic hepatitis B infection is available. For hepatitis C, a combination of drug therapy is available to treat chronic infection.

8. **What are the circumstances in which hepatitis A, B, or C could be significant?**
   Hepatitis A: There is no long-term infection risk associated with hepatitis A, and one cannot get the disease again after having it once, although upon initial infection, prolonged or relapsing symptoms may occur for 6 -9 months.
   Hepatitis B has more serious implications for chronic infection in infants, children, and adults. Persons who have hepatitis B are at risk for developing chronic hepatitis with its complications at advancing age, including liver cancer.
   Hepatitis C: Persons who have hepatitis C are at risk for developing chronic hepatitis with its complications at advancing age, including liver cancer.

9. **Exclusion:**
   Hepatitis A: Yes, children and adults, especially food handlers, with hepatitis A should be excluded for 1 week after onset of illness. Students should be referred to a health professional.
   Hepatitis B: Yes, if a child with known hepatitis B exhibits any of the following signs or symptoms: weeping sores that cannot be covered, bleeding problem, biting or scratching behavior that would lead to bleeding by the child with hepatitis B, generalized dermatitis that may produce wounds or weepy tissue fluids, the child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group, the child meets other exclusion criteria.
   Hepatitis C: Same as Hepatitis B.

10. **Readmission:**
    Hepatitis A: When all the following criteria are met: One week after the onset of illness and upon recovery from symptoms and after all contacts have received vaccine or immune globulin as recommended. When the child is able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group
    Hepatitis B: When all the following criteria are met: when skin lesions are dry or covered, when the child is able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.
    Hepatitis C: When skin lesions are dry or covered; when the child is cleared to return by a health professional.

11. **Contacts and reporting:** Reportable to the LACDPH (only acute cases are investigated); outbreaks of Hepatitis A may require immune globulin shots given by the health department. Call the CD Desk if there is a need to report a *confirmed* case of viral hepatitis.

HERPES

1. **What is herpes?** Herpes is an infection caused by two different but closely related viruses: herpes simplex virus type 1 and herpes simplex virus type 2. Both can cause sores in the mouth (oral herpes), genitals (genital herpes), or skin that encounters these areas. Genital herpes is a sexually transmitted disease. More serious complications of herpes infection can occur in the newborn and when the eyes are involved.

2. **What are the signs and symptoms of herpes?** Symptoms of oral herpes include "cold sores" or "fever blisters" that appear on the lips or inside the mouth. They are common in young children and harmless in children and adults. Symptoms of genital herpes include blistery sores that appear on the genitalia and buttocks that can be accompanied by pain in the infected area and flu-like symptoms. Sores can also be found on the skin, as in the case of wrestlers (herpes gladiatorum) or those with eczema (eczema herpeticum). After the primary infection, the virus persists for life and can result in occasional "flare-ups" or recurrence.

3. **Incubation period:** 2 days to 2 weeks.

4. **Contagious period:** The primary infection is generally communicable for 1 to 2 weeks after signs or symptoms appear. In recurrent infections, the largest amount of virus is shed for 3 to 4 days after signs or symptoms appear. There may be a low level of viral shedding when infected individuals have no signs or symptoms.

5. **How does infection with herpes occur?** Herpes is spread by touching, kissing, and sexual contact. It can be passed from one person to another or from one part of the body to another, even when sores are absent.

6. **How can infection with herpes be prevented?** Sores in the mouth or genital area should not be touched; prompt hand washing should follow if they are. People with sores in the mouth should avoid kissing and sharing food or drink with other people, especially infants, children, and pregnant women. Covering open herpes skin lesions is advisable. Wrestlers may need to have mats washed/disinfected between matches if there is suspicion or known herpes gladiatorum.

7. **Is there a treatment for herpes?** Antiviral medications, such as acyclovir, can be prescribed to help speed up the healing of sores and weaken the virus. Individuals with more than six episodes a year may be advised to take daily antiviral medications to prevent episodes.

8. **What are the circumstances in which herpes could be significant?** Herpes infections are much more serious in newborns. It is possible for a mother to pass herpes to her baby during birth, but the risk is much higher with primary infection of the mother.

9. **Exclusion:** No, unless the child has mouth ulcers and blisters and does not have control of drooling or the child meets other exclusion criteria (see "General Exclusion Criteria for Schools" page 6).
   Note: Athletes with exposed herpes lesions participating in close contact sport (e.g., wrestling) may need to be excluded from practice or competition until lesions heal or clearance from a licensed healthcare provider declaring the condition noninfectious.

10. **Readmission:** When all the following criteria are met: when a child with ulcers or vesicles inside the mouth is no longer drooling or the ulcers or vesicles have resolved; child with vesicles (blisters) on the body can return once these areas are covered with clothing or a bandage; when the child is able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

IMPETIGO

1. **What is impetigo?** Impetigo is a skin infection caused by bacteria (Group A *streptococci* or *Staphylococcus aureus*). Impetigo typically affects school-aged children, most often during the hot and humid summer months. It prefers skin that has already been injured by other skin problems, such as eczema or poison ivy. A potentially more serious strain of the bacterium *S. aureus* has emerged in recent years that is resistant to certain antibiotics (Methicillin-resistant *S. aureus*, or MRSA). Community-associated MRSA can be confused with impetigo, but they are clinically distinct entities.

2. **What are the signs and symptoms of impetigo?** Impetigo can affect skin anywhere on the body, but it most often affects the face. It causes itchy skin with tiny blisters, especially around the mouth and nose. Blisters will eventually burst to reveal areas of red skin that may weep fluid. Gradually, a tan or yellowish-brown crust will cover the infected area.

3. **Incubation period:** Variable. Bacteria that could cause impetigo commonly live harmlessly on the skin. Minor skin trauma may result in skin infections like impetigo.

4. **Contagious period:** Until the skin sores are treated with antibiotics for at least 24 hours or the crusting lesions are no longer present.

5. **How does infection with impetigo occur?** Impetigo can be passed from person to person. When someone in a household has impetigo, the infection can be passed to other family members on clothing, towels, and bed linens that have touched the infected person's skin. Impetigo can also be spread from one area of the skin to another by scratching. On the face, the infection usually spreads along the edges of an affected area, but it may also spread to more distant parts of the body on contaminated fingers.

6. **How can infection with impetigo be prevented?** Good general hygiene practices, such as daily bathing with soap and water, can help prevent impetigo. Areas of skin that have been injured should be kept clean and covered. Covering sores with gauze loosely to allow airflow can help prevent bacteria from spreading in group settings. If a family member is infected, all family members should use different towels.

7. **Is there a treatment for impetigo?** Impetigo is usually treated with antibiotics, which may be given by the mouth. In very mild cases, a topical antibiotic may be used.

8. **Exclusion:** Wash the affected area, cover the sores, and then, at the end of the day, the child should see a pediatric health professional. If impetigo is confirmed, the child should start treatment (oral or topical antibiotic) before returning. If treatment is started before the next day, no exclusion is necessary. However, the child may be excluded until treatment has started.

9. **Readmission:** See LAUSD's REF-4035.1, *Management of Skin Infections (including MRSA) in School Settings*, dated November 2, 2015. The child can return once appropriate treatment has started (oral or topical antibiotics). When possible, lesions should be kept covered until they are dry.

INFLUENZA

1. **What is the flu?** The flu is a contagious disease caused by the influenza virus that attacks the nose, throat, and lungs. Most people recover in 1-2 weeks, but some develop serious complications.

2. **What are the signs and symptoms of the flu?** Fever, chills, headache, tiredness, dry cough, sore throat, nasal congestion, and body aches are common flu symptoms. Children can have nausea, vomiting, and diarrhea.

3. **Incubation period:** 1 – 4 days, with a mean of 2 days.

4. **Contagious period:** From the day before, signs or symptoms appear until 7 days after the onset of flu. Children can be contagious longer.

5. **How does infection with the flu occur?** The flu spreads when an infected person coughs, sneezes or speaks and another person inhales this virus. It can also spread when a person touches a surface with the flu virus, such as a door handle, and then touches his or her nose or mouth.

6. **How can infection with the flu be prevented?** A flu shot can be obtained each fall, before flu season, for prevention. The elderly, people with chronic medical conditions or who are immunocompromised, and very young children (6 – 23 months) are recommended to get the flu shot as they are more likely to develop complications. Persons who care for or work with these high-risk groups may also be eligible for the flu shot. Please check with a school/CD nurse or the Department of Public Health regarding current indications for the immunization. Good personal hygiene, such as hand washing, can also help prevent infection.

7. **Is there a treatment for the flu?** The flu cannot be cured by medication, although some antiviral prescription drugs taken within the first two days of illness can reduce the duration of the disease. Rest, drinking plenty of liquids, avoiding alcohol and tobacco use, and taking nonprescription medication to relieve symptoms can help. A child or teenager with flu-like symptoms, particularly fever***,*** *should not* be given aspirin without first consulting a licensed healthcare provider, as a rare but serious illness called Reye's syndrome can result.

8. **What are the circumstances in which the flu could be significant?** While most people recover from the flu in 1-2 weeks, some develop life-threatening complications. People aged 65 years and older, people of any age with chronic conditions, and very young children are more likely to get complications from the flu, such as sinus and ear infections, bronchitis, and pneumonia. The flu can also make chronic health problems worse; for example, people with asthma may experience asthma attacks while they have the flu, and people with chronic congestive heart failure may experience worsening of their condition. Unusual flu strains (avian flu) may pose a greater risk to populations. The management, exclusion, and readmission of students and/or staff with avian flu may differ from the guidelines below.

9. **Exclusion:** None, unless the child meets other exclusion criteria such as fever with behavior changes, if the child appears to be severely ill, or if the child is unable to participate comfortably in activities as determined by the school staff (see "General Exclusion Criteria for Schools" page 6).

10. **Readmission:** When all the following criteria are met: when exclusion criteria are resolved, fever has been absent for 24 hours after any fever-reducing medicines have been given, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

MEASLES

1. **What is measles?** Measles (Rubeola) is an acute, highly contagious viral disease. It can be severe, with complications such as pneumonia and inflammation of the brain leading to death in about two out of every thousand cases.

2. **What are the signs and symptoms of measles?** The infected person first experiences a fever lasting about 2-4 days that can peak as high as 103-105 degrees Fahrenheit. This is followed by the onset of a cough, runny nose, conjunctivitis (pink eye), and Koplik spots (small red spots in the mouth). The rash (dusky, red, blotchy) usually begins at the hairline and then involves the face and upper neck. Over the next 3 days, the rash gradually proceeds downward on the body, reaching the hands and feet. Diagnostic testing for measles should be undertaken by a qualified health professional and the state public health laboratory.

3. **Incubation period:** 8 – 12 days (but up to 21 days in some cases) from exposure to onset of signs and symptoms.

4. **Contagious period:** 1 – 2 days before the first signs or symptoms appear (4 days before the rash) until 4 days after the appearance of the rash.

5. **How does infection with measles occur?** The disease is highly contagious and can be transmitted prior to and after the appearance of the rash. The virus resides in the mucus in the nose and throat of the infected person. When the infected person sneezes, coughs, or speaks, another person can inhale this virus from the air and become ill. Touching an infected surface can also spread the virus, which remains active and contagious on infected surfaces for up to 2 hours. Measles spreads so easily that anyone who is not immunized may get it.

6. **How can infection with measles be prevented?** The measles vaccine can prevent this disease. The vaccine is usually given as part of a combination vaccine called MMR, which protects against measles, mumps, and rubella. An immune globulin can be given after exposure to measles, usually for immunocompromised and unimmunized patients.

7. **Is there a treatment for measles?** There is no cure or treatment for measles; only its symptoms can be treated.

8. **What are the circumstances in which measles could be significant?** Complications of measles are more common among children under 5 years of age and adults over 20 years old and can include ear infection, pneumonia, encephalitis (brain inflammation), and death. Measles in pregnant women can result in miscarriage, premature birth, or a low-birth-weight baby.

9. **Exclusion:** Yes**,** measles is a highly communicable illness for which routine exclusion of infected children is warranted. Unimmunized children should be excluded. If unimmunized, exposed children are excluded for this reason, they may be readmitted on receiving measles immunization. If they remain unimmunized, they should be excluded for 21 days after the onset of rash in the last case of measles. Immune globulin may prevent or modify measles disease in an unimmunized susceptible person if given within 6 days of exposure, especially infant younger than 6 months, pregnant women, and those with immune deficiency.

10. **Readmission:** Four days after the rash begins, with clearance from LACDPH, or licensed health care provider.

11. **Contacts and reporting:** Measles is reportable to the LACDPH. Call the CD Desk if there is a need to report a *confirmed* case of measles.

MENINGITIS

1. **What is meningitis?** Meningitis is an infectious disease that causes swelling and inflammation of the membranes and fluid surrounding the brain and spinal cord. It can be caused by a bacterium or a virus. Knowing whether meningitis is caused by a virus or bacterium is important because the severity of illness and the treatment differ. Viral meningitis is generally less severe and resolves without specific treatment, while bacterial meningitis caused by meningococcal bacteria is a serious disease and can be fatal. Unlike viral meningitis, bacterial meningitis must be treated with antibiotics.

2. **What are the signs and symptoms of meningitis?** Often, the symptoms of viral meningitis and bacterial meningitis are the same. High fever, headache, and stiff neck are common symptoms of meningitis in anyone over the age of 2 years. These symptoms can develop over several hours or take 1-2 days. Other symptoms may include nausea, vomiting, discomfort looking into bright lights, confusion, and sleepiness. As the disease progresses, patients may have seizures. Children infected with meningococcal bacteria can have a quickly progressing course, including a dusky-purple rash and shock or coma.

3. **Incubation period:**
   For the most common cause of viral meningitis (enterovirus): 1 to 10 days, usually less than 4 days.
   For Hib: unknown.
   For meningococcus and pneumococcus: 1 to 10 days.

4. **Contagious period:**
   For enterovirus viral meningitis: Shedding of the virus in feces can continue for several weeks, but shedding from the respiratory tract usually lasts a week or less.
   For Hib, meningococcus, and *S pneumoniae*: Until after 24 hours of antibiotics.

5. **How does infection with meningitis occur?** Most viruses and bacteria that cause meningitis spread through person to person contact and respiratory secretions. Some viruses are spread through fecal-oral routes.

6. **How can infection with meningitis be prevented?** There are safe and effective vaccines against some bacteria that cause meningitis. One effective prevention method for viral and bacterial infections is washing hands thoroughly and often. In institutional settings such as schools and childcare centers, washing objects and surfaces with a District-approved disinfectant (e.g., dilute bleach solution) can effectively inactivate a virus. In some cases of bacterial meningitis, antibiotic prophylaxis may be indicated for close contact with the infected individual.

7. **Is there a treatment for meningitis?** Bacterial meningitis can be treated with several effective antibiotics, but no specific treatment exists for viral meningitis at this time. Depending on their general condition and the severity of their disease, individuals with meningitis may be managed in the hospital.

8. **Exclusion:** Yes, as soon as it is suspected.

9. **Readmission:** When the child is cleared in writing to return by a licensed health professional.

10. **Contacts and reporting: Meningitis** (bacterial) is a reportable condition. Call the CD Desk if there is a suspected case of meningitis. Medical evaluation and diagnosis is required in order for the CD Desk to report this case to LACDPH.

MOLLUSCUM CONTAGIOSUM

1. **What is molluscum contagiosum?** Molluscum is a benign skin disease caused by a virus, somewhat like warts. Humans are the only known source of the virus. While infectivity is generally low, occasional outbreaks have been reported, including in childcare centers.

2. **What are the signs and symptoms of molluscum contagiosum?** Molluscum only affects the skin and no other parts of the body. It is characterized by small, flesh-colored bumps on the skin, often with a tiny, hard, indented, seed-like center. Lesions commonly occur on the trunk, face, arms, and legs but rarely are generalized over the entire body. The exceptions are eczema or immunocompromised people, who tend to have more intense and widespread eruptions.

3. **Incubation period:** Usually between 2 and 7 weeks but may be as long as 6 months.

4. **Contagious period:** Unknown.

5. **How does infection with molluscum contagiosum occur?** The virus is spread from person to person through close contact or inanimate objects such as towels. Infectivity is generally considered low.

6. **How can infection with molluscum contagiosum be prevented?** Although molluscum contagiosum bumps represent a viral infection, they are very mildly contagious and most often spread to other areas of the affected child's body rather than to other children. Children should avoid scratching the bumps, as they can become infected with bacteria or further spread the virus to another site. As with other communicable diseases, hand washing and not sharing personal objects (towels) with infected individuals are important. Molluscum contagiosum bumps do not need to be covered like shingles or other oozing sores.

7. **Is there a treatment for molluscum contagiosum?** Treatment is a personal choice, not an infection control issue for a group care setting. The bumps usually go away on their own in a few months (6 to 12 months) as the person develops antibodies to the virus. Alternatively, treatments may be used; however, there is little agreement on effective treatments.

8. **Exclusion:** No.

9. **Readmission:** No restrictions.

MONONUCLEOSIS

1. **What is mononucleosis?** Mononucleosis is an infectious disease caused by the Epstein-Barr Virus (EBV), commonly known among the public as "mono." Most people become infected with EBV at one point during their lives but do not necessarily develop mononucleosis.

2. **What are the signs and symptoms of mononucleosis?** Symptoms of infectious mononucleosis include fever, sore throat, swollen lymph glands, and fatigue. Sometimes, a swollen spleen or liver involvement may develop. Heart problems or involvement of the central nervous system occur only rarely.

3. **Incubation period:** Estimated to be 30 – 50 days.

4. **Contagious period:** Virus is excreted for many months after infection, and virus excretion can occur intermittently throughout life.

5. **How does infection with mononucleosis occur?** Most individuals exposed to people with infectious mononucleosis have previously been infected with the virus and are not at risk for infectious mononucleosis. Transmission of the virus requires intimate contact with the saliva of an infected person; transmission through the air or blood does not normally occur, although infection has been reported through blood transfusion.

6. **How can infection with mononucleosis be prevented?** Avoiding direct contact with the saliva of an infected person may help prevent transmission. However, the fact that many healthy people can carry and spread the virus intermittently for life, and that they are usually the primary reservoir for person-to-person transmission, makes the transmission of the virus almost impossible to prevent. Generally, people with signs and symptoms of mononucleosis should not donate blood or prepare food for others.

7. **Is there a treatment for mononucleosis?** Only the symptoms of mononucleosis may be treated. No vaccine or antiviral drugs are available currently.

8. **What are the circumstances in which mononucleosis could be significant?** Rupture of an organ is a risk in patients with an enlarged spleen or liver who play contact sports. In rare instances, bleeding disorders or testicular or cardiac inflammation can lead to more severe complications of EBV infection. EBV has also been associated with distinct types of cancer.

9. **Exclusion:** No, unless the child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group or the child meets other exclusion criteria.

10. **Readmission:** Yes, when exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group. School-aged children should avoid contact sports if they have an enlarged spleen until the spleen is no longer enlarged.

MOSQUITO-BORNE DISEASES

1. **What are mosquito-borne diseases?** Diseases spread by infected mosquitoes—in the United States, most are caused by viruses.
   - Examples of such viruses include West Nile virus, eastern and western equine encephalomyelitis, St. Louis and La Crosse encephalitis, dengue, chikungunya, and Zika virus. West Nile virus is established as a seasonal epidemic in North America, with flares in months with more mosquitoes (summer-fall). In children, most of these infections produce no signs or symptoms or mild headaches and fever. More severe illness (including central nervous system involvement) can occur, especially among adults.
   - Dengue and chikungunya are mosquito-borne viruses that have recently been introduced into the United States. Dengue has caused illness in certain southern states in recent years and is common in Puerto Rico, the Virgin Islands, and American Samoa, where children may vacation with parents. Chikungunya is another recent virus spread by mosquitos that has come to the United States. Hundreds of cases are reported in the United States each year, nearly all from international travelers.
   - Zika is a mosquito-borne disease that usually causes mild illness that lasts from several days to a week. Outbreaks of Zika have occurred in Africa, Southeast Asia, the Pacific Islands, and the Americas but have been spreading to new areas of the world. Zika infection can be transmitted from mosquito bites, sexual contact, and an infected pregnant mother to her fetus. Most cases in the United States occur from travelers returning from affected areas, but small numbers of locally acquired infection from mosquitoes in the United States began in 2016 in Florida and Texas. For the most recent information, visit the Centers for Disease Control and Prevention (CDC) and search Zika virus. When Zika virus infects a pregnant woman, it can spread to her fetus and cause microcephaly and other brain defects. The CDC recommends pregnant women consider putting off travel to areas where Zika virus is spreading, use repellents and other measures to avoid mosquito bites if they do travel to these areas, and use condoms for sexual activity of any type while pregnant.

2. **What are the signs and symptoms of West Nile virus**:
   - Many people have few signs or symptoms.
   - Fever, headache, joint pain and/or body aches
   - Nausea and/or vomiting
   - Rash
   - Convulsions, coma, paralysis (in West Nile disease, paralysis of the facial muscles [Bell palsy] has been noted).
   - Conjunctivitis (pinkeye or red eyes) for Zika

3. **Incubation period:**
   - West Nile virus 2 to 14 days
   - EEE 3 to 10 days
   - SLE 4 to 14 days
   - La Crosse encephalitis 5 to 15 days
   - WEE 2 to 10 days
   - Zika 2 to 14 day

4. **Contagious period:** These infections are not contagious except for the Zika virus, which can be transmitted from person to person; the virus has been detected in blood, urine, saliva, and semen for weeks after initial infection.

5. **How does infection with mosquito-borne diseases occur?** Mosquito-borne disease occurs through the bite of an infected mosquito. West Nile virus and Zika virus may rarely be transmitted through transplanted organs or blood transfusion from a mother to her fetus. There is no evidence that mosquito-borne diseases can be spread from person to person under normal casual contact.

6. **What can be done to reduce the risk of infection with mosquito-borne diseases?** Protective measures to prevent mosquito-borne disease exposure include:
   - Avoid activity outside when mosquitoes are most active, especially at dawn and dusk.
   - Wear long pants, long-sleeved shirts, and other protective clothing outdoors.
   - Fit doors and windows with tight-fitting screens; repair or replace torn screens.
   - Eliminate all sources of standing water that can support mosquito breeding.
   - Contact your local mosquito and vector control agency.

   If there is a significant mosquito problem at your site, please contact the Pest Management Unit at:
   Central (M&O C-3)..... (213) 745-1400
   Region North (M&O N-2)..... (818) 394-2400
   Region South (M&O S-1)..... (323) 789-5000

7. **Is there a treatment for mosquito-borne disease?** There is no specific treatment for mosquito-borne disease infection. In more severe cases, intensive supportive therapy is indicated, often involving hospitalization.

8. **What are the circumstances in which mosquito-borne disease could be significant?** Persons over 50 years of age have the highest risk of severe disease (i.e., developing encephalitis).

9. **Exclusion:** No unless the child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group or they meet other exclusion criteria (see "General Exclusion Criteria for Schools" page 6).

10. **Readmission:** When exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

11. **Contacts and reporting:** Dead birds may be a sign of West Nile virus disease, and they should not be handled with bare hands. Contact the Pest Management Unit (see contact information above) and/or CDPH West Nile Virus website, https://westnile.ca.gov/report, and Hotline at (877) 968-2473 for information on disposal and reporting.

MPOX

1. **What is Mpox?** Mpox is a disease caused by infection with the monkeypox virus. It is a rare disease and does not naturally occur in the United States. Most cases in the U.S. are associated with travel to West or Central Africa or contact with imported infected animals. Cases began appearing in 2022 in many countries where the virus is not typically found, including the U.S., and appear to have spread through human-to-human contact.

2. **What are the signs and symptoms of Mpox?** Early signs may include fever, muscle aches, headache, swollen lymph nodes, exhaustion, and sometimes cough or sore throat. A rash often develops on the face and spreads to other parts of the body, including the hands, feet, eyes, mouth, and/or genitals. Rashes may vary in severity between people and change in appearance through infection. Infections can last 2-4 weeks. Skin lesions typically develop simultaneously, may appear anywhere on the body, and change from flat to bumps to blisters before scabbing over and resolving. Mpox rash can be confused with other rash illnesses that are commonly considered in children, including varicella (chickenpox); hand, foot, and mouth disease; measles; scabies; molluscum contagiosum; herpes; syphilis; allergic skin rashes; and drug eruptions.

3. **Incubation period:** 5 to 21 days after a person has been exposed.

4. **Contagious period:** People can spread Mpox while they have symptoms. Therefore, they are contagious from the time their symptoms start until their rash and scabs heal.

5. **How does infection with Mpox occur?** Mpox can spread when a person has close contact with a person infected with the virus by touching Mpox lesions on a person's skin or when a person encounters materials (e.g., bedding, towels, clothing, surfaces) that are contaminated with the virus. Mpox can also spread when a person encounters respiratory droplets or secretions from the eyes, nose, and mouth of a person with Mpox. The Mpox virus can also spread from animals to people.

6. **How can infection with Mpox be prevented?** To prevent the spread of the monkeypox virus, people should avoid close contact with people with a rash that looks like Mpox. Avoid handling clothes, sheets, blankets, or other materials that have been in contact with an infected animal or person. Isolate people who have Mpox from healthy people. Wash your hands well with soap and water after any contact with an infected person or animal. Avoid animals that may carry the virus. Some smallpox vaccines can prevent Mpox. Healthcare providers may suggest that people exposed to Mpox get vaccinated.

7. **Is there a treatment for Mpox?** There are no specific treatments approved for monkeypox virus infections. Most treatment is supportive, easing the illness symptoms. For the pediatric population, attention should be paid to keeping skin lesions covered and preventing children from scratching or touching their eyes. Optimal fluid intake should be encouraged, particularly in persons with extensive skin involvement who may have additional fluid losses. However, antivirals developed for use in patients with other viral diseases (like smallpox) may be recommended in certain cases (patients with severe disease, complications, or at risk for severe disease). Vaccinations may be given to prevent Mpox infection after a high-risk exposure to the virus.

8. **What are the circumstances in which Mpox could be significant?** Most people with Mpox will recover on their own. But 5% of people with Mpox die. It appears that the current strain causes less severe disease. The mortality rate is about 1% with the current strain. Young children, children with eczema and other skin conditions, and children with immuno-compromising conditions may be at increased risk of severe disease. Rarely, Mpox can result in complications including encephalitis, cellulitis, pneumonia, sepsis, abscess, airway obstruction due to severe lymphadenopathy, keratitis, and corneal scarring.

9. **Exclusion and Readmission:** If a student has a rash of unknown origin, refer them to their licensed healthcare provider for further evaluation. If a Mpox case is identified or suspected at school, the student or employee should be excluded until they provide written medical clearance from their primary care provider or the LACDPH. The student or employee should be allowed to return with medical clearance once they have been fever-free for at least 24 hours without fever-reducing medication, their symptoms have improved, and their rash and scabs have healed.

10. **Contacts and reporting:** Currently, Mpox is a reportable condition. All healthcare providers are to report all Los Angeles County residents with positive Mpox and/or presumptive positive test results from commercial laboratories to the LACDPH. The student's healthcare provider should report cases online via the LACDPH's secure Mpox reporting portal on their website. Call the CD Desk if there is a confirmed case of Mpox at your school for advisement. The CD Desk will notify LACDPH of the case and provide the school with the next steps.

MRSA

1. **What is MRSA?** MRSA is caused by a skin infection caused by methicillin-resistant *Staphylococcus aureus*, a type of staph bacteria resistant to several antibiotics. In the general community, MRSA can cause skin and other infections.

2. **What are the signs and symptoms of MRSA?** Community-associated MRSA usually presents as pimples, boils, or abscesses. They may be painful and may be misdiagnosed as "spider bites." School personnel generally only know that a student is infected with MRSA if given the diagnosis by a health care provider as it may be difficult to distinguish from other common skin infections. Most staph skin infections, including MRSA, appear as a bump or infected area on the skin that might be:
   - Red
   - Swollen
   - Painful
   - Warm to the touch
   - Full of pus or other drainage
   - Accompanied by a fever

3. **Incubation period:** Unknown.

4. **Contagious period:** Children are contagious with *S aureus* when they have actively draining sores or boils. But children may also be contagious with *S aureus* without any symptoms (carriers).

5. **How does infection with MRSA occur?** MRSA can be passed from person to person. When someone in a household has MRSA, the infection can be passed to other family members on clothing, towels, and bed linens that have touched the infected person's skin. MRSA can also be spread from one area of the skin to another by scratching. On the face, the infection usually spreads along the edges of an affected area, but it may also spread to more distant parts of the body on contaminated fingers.

6. **How can infection with MRSA be prevented?** Good general hygiene practices, such as daily bathing with soap and water, can help prevent MRSA. Areas of infected skin should be kept clean and covered. Covering sores with gauze loosely to allow airflow can help prevent bacteria from spreading in group settings. If a family member is infected, all family members should use different towels.

7. **Is there a treatment for MRSA?** MRSA is usually treated with antibiotics, which may be given by the mouth. In very mild cases, a topical antibiotic may be used.

8. **Exclusion:** No, unless the child is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group; the child meets other exclusion criteria; or the lesions cannot be covered so that contact with others and surfaces with drainage does not occur. Having a MRSA infection or harboring MRSA is not a reason for exclusion unless other exclusion criteria are met.

9. **Readmission:** Yes, when exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

MUMPS

1. **What is mumps?** Mumps is an acute viral illness with swelling of 1 or more of the salivary glands. Uncommon in children with up-to-date immunizations.

2. **What are the signs and symptoms of mumps?** Mumps begin with a low-grade fever, headache, earache, loss of appetite, muscle aches, and a generalized sick feeling. Mumps most commonly affect the parotid glands in front and below the ear or under the jaw (no swelling or symptoms in one-third of infection). Within 2 days, the infection in the salivary glands begins to be marked with an earache and/or jaw pain. Symptoms tend to decrease after one week and usually resolve in 10 days. Some infections show no symptoms, while others may show only non-specific or respiratory symptoms. In teenage boys, painful swelling of the testicles may appear; girls may have swelling of the ovaries, which may cause abdominal pain.

3. **Incubation period:** 16 – 18 days but may be up to 12-25 days after exposure.

4. **Contagious period:** From several days before to 5 days after onset of swelling of glands.

5. **How does infection with mumps occur?** Transmission of mumps virus occurs when a healthy person encounters an infected person's saliva or when an infected person spews airborne droplets containing the virus by coughing, sneezing, or talking, and a healthy person breathes them in.

6. **How can infection with mumps be prevented?** The mumps vaccine can prevent this disease. The vaccine is usually given as part of a combination vaccine (MMR) that protects against measles, mumps, and rubella.

7. **What are the circumstances in which mumps could be significant?** Mumps may cause meningitis, deafness (usually permanent), glomerulonephritis (kidney inflammation), and inflammation of joints.

8. **Exclusion:** Yes, mumps is a highly communicable illness for which routine exclusion of infected children is warranted. For outbreaks, exclude exposed children who have not been immunized until they become immunized; or, if they are not immunized because of an accepted exemption, continue to exclude them until the health department determines it is safe for them to return. If they remain unimmunized, they should be excluded until at least 26 days after onset of swelling in the last case.

9. **Readmission:** Five days after onset of symptoms (swelling of glands) and when the child is able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group. The school should obtain clearance from the (LACDPH) or the treating licensed healthcare provider.

10. **Contacts and reporting:** Mumps is reportable to the LACDPH. Call the CD Desk if there is a need to report a *confirmed* case of mumps.

NOROVIRUSES

1. **What is a Norovirus?** A virus that causes diarrhea and vomiting. Disease occurs more frequently in cooler months (i.e., late autumn to early spring) than other times of the year.

2. **What causes Norovirus?** Fecal-oral route: Contact with feces or vomit of children or adults who are infected. This generally involves an infected person contaminating their own fingers and then touching an object that another person touches. The person who touched the contaminated surface then puts their fingers into their own mouth or another person's mouth. Water or food contaminated by human feces.

3. **Incubation period:** 12 to 48 hours after exposure.

4. **Contagious period:** Virus may be present before vomiting or diarrhea begins and can persist for 4 weeks or more.

5. **How is infection with noroviruses diagnosed?** A rapid stool test can detect rotavirus or norovirus, but there are no quick tests for other viruses that cause gastroenteritis. In some cases, your doctor may have you submit a stool sample to rule out a possible bacterial or parasitic infection.

6. **How can infection be prevented?** Always use good hand-hygiene techniques, especially after toilet use or handling soiled diapers and before anything to do with food preparation or eating. For norovirus, washing hands with soap and water is better than alcohol-based hand sanitizer, which does not adequately kill the virus. Norovirus is highly contagious. Ensure proper surface disinfection that includes cleaning and rinsing of surfaces that may have become contaminated with stool (feces) with detergent and water and application of a US Environmental Protection Agency–registered disinfectant according to the instructions on the product label. Ensure proper cooking and storage of food. Exclude infected staff members who handle food. Exclude children and adults who have specific symptoms.

7. **Is there a treatment for Noroviruses?** You treat gastroenteritis caused by noroviruses by managing any complications until it passes. Dehydration caused by diarrhea and vomiting is the most common complication. Do not use medicines unless your health care provider recommends them. Caution parents to avoid OTC meds like adult Pepto Bismol (there is a children's version that is aspirin-free), which may cause Reyes Syndrome.

8. **Exclusion:** Yes, if the person is symptomatic or meets other exclusion criteria (see "General Exclusion Criteria for Schools" page 6). Please be aware that keeping students at home for 48 hours until the resolution of their gastrointestinal symptoms is necessary for preventing the spread of illnesses such as this. Handwashing is also imperative in preventing this illness from spreading any further. Thorough environmental cleaning of the surfaces the ill students may have handled would be beneficial, although no special cleaning is required. Ensuring a thorough cleaning of the classrooms/environment would be helpful with the usual district-approved cleaning products (Medic) your plant manager routinely uses.

9. **Readmission:** Once diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children do not have toileting accidents. Once stool frequency is no more than 2 stools above normal for that child during the time the child is in the program, even if the stools

remain loose. When the child is able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

10. **Contacts and reporting:** Norovirus is not reportable. However, if more than 10% of the school or 20% of the classroom is affected, the school should call the CD Desk for guidance.

PERTUSSIS

1. **What is pertussis or whooping cough?** Whooping cough is an acute infection caused by the bacterium *Bordetella pertussis*. It is one of the most common childhood diseases involving the throat and lungs, especially encountered in unimmunized populations. Whooping cough is a serious illness in children and may result in complications and death. Adolescents and adults who become infected with whooping cough, although contagious, usually have a milder illness.

2. **What are the signs and symptoms of whooping cough?** It begins with cold-like signs or symptoms. Coughing may progress to sudden, severe coughing, which may cause vomiting while coughing, loss of breath; difficulty catching breath, cyanosis (i.e., blueness), whooping (i.e., high-pitched crowing) sound when inhaling after a period of coughing (may not occur in very young children). Coughing persists for weeks to months. Fever is usually absent or minimal. Symptoms are more severe in infants (those younger than 12 months). Infants younger than 6 months may develop complications and often require hospitalization.

3. **Incubation period:** 5 – 21 days, usually 7 – 10 days.

4. **Contagious period:** From the beginning of symptoms until 3 weeks after the cough begins, depending on age and immunization status. An infant without pertussis immunization may remain infectious for 6 weeks or more after the cough starts.

5. **How does infection with whooping cough occur?** Transmission of the whooping cough bacteria from one person to another usually occurs through direct contact with or inhalation of airborne droplets of respiratory secretions. Less commonly, transmission can occur through contact with freshly contaminated objects touched by an infected person.

6. **How can infection with whooping cough be prevented?** Whooping cough is a vaccine-preventable disease; however, protection is incomplete and decreases over time. Other measures include hand washing and prophylactic antibiotics for exposed close contacts.

7. **Is there a treatment for whooping cough?** Antibiotics can be used to treat whooping cough.

8. **What are circumstances in which whooping cough could be significant?** Young infants are at the highest risk of developing complications from whooping cough. The most common complication is bacterial pneumonia. Neurologic complications such as seizures, etc., may also occur because of a reduced oxygen supply to the brain due to coughing.

9. **Exclusion:** Yes, pertussis is a highly communicable illness for which routine exclusion of infected children is warranted. Exclude close contacts who are coughing until they receive appropriate evaluation and treatment.

10. **Readmission:** After 5 days of appropriate antibiotic treatment (some treatments may be given for 14 days) and with clearance from the LACDPH or the licensed healthcare provider. People who do not receive appropriate antibiotic therapy should be excluded from school for 21 days after the onset of symptoms.

11. **Contacts and reporting:** Whooping cough (pertussis) is a reportable disease. Call the CD Desk if you have a confirmed case.

PNEUMONIA

1. **What is pneumonia?** Pneumonia is lung inflammation caused by bacterial or viral infection, in which the air sacs fill with pus and may become solid. Inflammation may affect both lungs (*double pneumonia*), one lung (*single pneumonia*), or only certain lobes (*lobar pneumonia*).

2. **What are the signs and symptoms of pneumonia?** Cough (with green, yellow, or even bloody mucus), sweating, fever, shaking chills, shortness of breath, rapid, shallow breathing, sharp or stabbing chest pain that worsens when you breathe deeply or cough, loss of appetite, low energy, and fatigue.

3. **Incubation period:** Typically, about 1 to 3 days, however pneumonia is a condition caused by a variety of types of germs; therefore, incubation periods will vary depending on the germ causing the pneumonia.

4. **Contagious period:** The period of communicability for pneumococcal disease is unknown. Presumably, transmission can occur if the organism appears in respiratory secretions. It could be days or weeks and depends on the germ causing the pneumonia.

5. **How does infection with pneumonia occur?** Pneumonia does not spread. The germ that causes pneumonia can spread if the person is still infectious at the time the pneumonia develops. Most of the germs that cause pneumonia spread by direct or close contact with mouth and nose secretions and touching contaminated objects.

6. **How can infection with pneumonia be prevented?** Vaccines can help prevent some types of pneumonia. Good hygiene (washing your hands often), quitting smoking, and keeping your immune system strong by getting regular physical activity and eating healthy are other ways to lower your risk of getting pneumonia. Reducing crowding by ensuring space and ventilation meet the requirements in national standards. Prevent contact with respiratory secretions. Teach children and educators to cover their noses and mouths when sneezing or coughing with disposable facial tissue, if possible, or with an upper sleeve or elbow if no facial tissue is available in time. Teach everyone to remove any mucus or debris on skin or other surfaces and perform hand hygiene right after using facial tissues or having contact with mucus to prevent the spread of disease by contaminated hands. Change or cover clothing that has mucus on it. Dispose of facial tissues that contain nasal secretions after each use. Sanitize surfaces that are touched by hands frequently, such as toys, tables, and doorknobs.

7. **Is there a treatment for pneumonia?** Antibiotics are prescribed for bacterial pneumonia, antiviral medication can be prescribed for viral pneumonia, and antifungal medicines are prescribed for fungal pneumonia. OTC medicines will be recommended to treat fever and muscle pain or to assist with breathing.

8. **What are circumstances in which pneumonia could be significant?** Complications of pneumonia can be acute respiratory distress syndrome, lung abscesses, respiratory failure, sepsis, pleural effusion, or other respiratory/systemic issues. Seek a doctor's evaluation immediately if there is difficulty breathing, a bluish color in the lips and fingertips, chest pain, high fever, or a cough with mucus that is severe or getting worse.

9. **Exclusion:** No, unless the student is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group. The student may be excluded if they meet other exclusion criteria.

10. **Readmission:** When exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

11. **Contacts and reporting:** Pneumonia is not reportable.

RESPIRATORY SYNCYTIAL VIRUS (RSV)

1. **What is Respiratory Syncytial Virus or RSV?** Respiratory syncytial (sin-SISH-uhl) virus, or RSV, is a common respiratory virus that usually causes mild, cold-like symptoms. RSV is the most common cause of bronchiolitis (inflammation of the small airways in the lung) and pneumonia (infection of the lungs) in children younger than 1 year of age in the United States. RSV circulation in the United States usually starts during fall and peaks in the winter.

2. **What are the signs and symptoms of RSV?** Cold-like signs or symptoms (runny nose, congestion, cough) for most children. Very young infants also can exhibit irritability, poor feeding, lethargy, apnea (i.e., brief periods of no breathing), cyanosis (skin or mucous membranes turn blue, usually when coughing with respiratory syncytial virus [RSV].) Respiratory problems include bronchiolitis (i.e., wheezing from narrowed airways in the lungs), pneumonia, wheezing and asthma attack in children who already have asthma; children with weakened immune systems, preterm birth, or heart or lung problems have greater difficulty when ill with this infection compared with otherwise healthy children. Very young infants (<6 months) have higher risk of hospitalization due to RSV.

3. **Incubation period:** The average incubation period is 5 days, ranging from 2 to 8 days.

4. **Contagious period:** People infected with RSV are usually contagious for 3 to 8 days and may become contagious a day or two before showing signs of illness. However, some infants and people with weakened immune systems can continue to spread the virus even after they stop showing symptoms for as long as 4 weeks.

5. **How does infection with RSV occur?** RSV can spread when: An infected person coughs or sneezes**;** virus droplets from a cough or sneeze get in your eyes, nose, or mouth**;** a person has direct contact with the virus, like kissing the face of a child with RSV**;** a person touches a surface that has the virus on it and then touches their face before washing their hands. RSV can survive on hard surfaces such as tables and crib rails for many hours. It usually lives on soft surfaces such as tissues and hands for a shorter time.

6. **How can infection with RSV be prevented?** The following are steps that can be taken to prevent the spread of RSV: Cover your coughs and sneezes with a tissue or cough or sneeze into your elbow, not your hand**;** wash your hands often with soap and water for at least 20 seconds**;** avoid close contact, such as kissing and shaking hands with others**;** stay home from work or school when sick, until symptoms improve**;** avoid sharing cups and eating utensils with others**;** clean frequently touched surfaces**.** Some young babies at the highest risk for severe RSV disease may be able to receive medication that can protect against severe disease from RSV. This medication is given by healthcare providers to premature infants and young children with certain heart and lung conditions as a series of monthly shots during RSV season. Parents or guardians who are concerned about their child's risk for severe RSV infection should talk to their child's healthcare provider.

7. **Is there a treatment for RSV?** Most RSV infections go away on their own in a week or two. There is no specific treatment for RSV infection. Still, you can take the following steps to relieve symptoms: Manage fever and pain with over-the-counter fever reducers and pain relievers, such as acetaminophen or ibuprofen (never give aspirin to children); drink enough fluids to prevent dehydration (loss of body fluids);

talk to your healthcare provider before giving your child nonprescription cold medicines as some medicines contain ingredients that are not good for children.

8. **What are circumstances in which RSV could be significant?** Occasionally, RSV infection can cause lower respiratory infections like bronchiolitis and pneumonia. RSV infection can also sometimes lead to exacerbations of chronic health conditions such as asthma, chronic obstructive pulmonary disease (COPD), or congestive heart failure. People most at risk of serious illness from RSV infection include**:**
   - Premature infants
   - Young children with congenital (from birth) heart or chronic lung disease
   - Young children with weakened immune systems due to a medical condition or medical treatment
   - Children with neuromuscular disorders
   - Adults with weakened immune systems
   - Older adults, especially those with underlying heart or lung disease

9. **Exclusion:** No, unless the student exhibits rapid or labored breathing or cyanotic (blue) episodes. (Immediately refer a child with these symptoms to a health professional.); the student is unable to participate and staff members determine they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group; or the student meets other exclusion criteria.

10. **Readmission:** When exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

11. **Contacts and reporting:** This is non-reportable, but if a school has several confirmed cases (20% of a classroom or 10% of the entire school population), please call the CD Desk.

RINGWORM

1. **What is ringworm?** Ringworm is a contagious fungal infection of the skin (tinea corporis), scalp (tinea capitis), feet (tinea pedis), and nails (tinea unguium). Despite its name, it has nothing to do with worms. The name comes from the characteristic red ring that can appear on an infected person's skin.

2. **What are the signs and symptoms of ringworm?** Ringworm of the body shows up as a flat, round patch anywhere on the skin except for the scalp and feet. The groin is a common area of infection. As the rash gradually expands, its center clears to produce a ring, and scales may be on the edges. More than one patch might appear, and the patches can overlap. The area is sometimes itchy.
   Ringworm of the scalp begins with a small pimple that becomes larger, leaving scaly patches of temporary baldness. Infected hairs become brittle. Yellowish crusty areas sometimes develop.
   Ringworm of the foot is also called "athlete's foot." It appears as a scaling or cracking of the skin, especially between the toes.
   Ringworm of the nails causes the infected nails to become thicker, discolored, and brittle or to become chalky and disintegrate.

3. **Incubation period:** 1 to 3 weeks but can be shorter, typically 10 – 14 days.

4. **Contagious period:** A child with ringworm of the skin is infectious as long as the fungus remains present in the skin lesion. The fungus is no longer present when the lesion starts to shrink. Spores of the fungus that cause ringworm of the scalp are found on objects in the environment and on people who have no obvious lesions. Once the child begins treatment with a medication taken by mouth, the child is no longer considered infectious.

5. **How does infection with ringworm occur?** People can get ringworm by direct skin-to-skin contact with an infected person or pet. People can also get ringworm indirectly by contact with objects or surfaces that an infected person or pet has touched, such as hats, combs, brushes, bed linens, stuffed animals, gym mats, and shower stalls. In rare cases, ringworm can be spread by contact with soil.

6. **How can infection with ringworm be prevented?** Early treatment of infected people. Examination of siblings and other household contacts. Not sharing ribbons, combs, or hairbrushes. Launder ribbons and dress-up clothes between users. Do not permit sharing of bike helmets without wiping the contact surfaces of the helmet between users with a cloth dampened with water. Do not use anything other than water to clean the surface of a helmet because some products contain chemicals that make the impact-absorbing materials and straps less safe. Covering skin lesions.

7. **Is there a treatment for ringworm?** Ringworm can be treated with anti-fungal medicine. The medicine can be in tablet or liquid form taken by mouth or as a cream applied directly to the infected area. Anti-fungal creams can be purchased in a pharmacy, without a prescription, for ringworm of the skin and foot. More extensive infections and ringworm of the scalp and nails usually require prescription medication.

8. **What are the circumstances in which ringworm could be significant?** Lack of or inadequate treatment can result in an infection that will not clear up.

9. **Exclusion:** At the end of the day, the child should consult a pediatric health professional and, if ringworm is confirmed, the child should start treatment before returning. If treatment starts before the next day, no exclusion is necessary. However, the student may be excluded until treatment has started.

10. **Readmission:** Once treatment is started. Athletes with ringworm of the body (tinea corporis) in sports with person-to-person contact cannot participate in matches for 72 hours after starting treatment unless area can be covered.

RUBELLA (GERMAN MEASLES)

1. **What is rubella?** A mild viral infection usually lasting 3 days that is now rare in the United States because of routine immunization.

2. **What are the signs and symptoms of rubella?** Symptoms of rubella may include a rash, slight fever, aching joints, headaches, discomfort, runny nose, and redness of eyes. A red or pink rash first appears on the face and spreads from head to toe. The lymph nodes just behind the ears and at the back of the neck may swell, causing soreness and pain. Many people with rubella have few or no symptoms, and only about half of the people who have the disease get a rash.

3. **Incubation period:** 14 to 21 days but is usually 16 – 18 days.

4. **Contagious period:** May be spread 7 days before to 14 days after the appearance of the rash however children are most contagious from 3 to 4 days before the rash starts until 7 days after the rash.

5. **How does infection with rubella occur?** Rubella is spread from person to person when an infected person coughs or sneezes and an uninfected person comes in direct contact with these respiratory and throat secretions or contaminated objects. In addition, a mother can pass rubella to her fetus.

6. **How can infection with rubella be prevented?** There is a safe and effective vaccine to protect against rubella. The vaccine is usually given as part of a combination vaccine called the MMR vaccine, which protects against measles, mumps, and rubella.

7. **Is there a treatment for rubella?** Only the symptoms of rubella can be treated.

8. **What are the circumstances in which rubella could be significant?** If rubella is contracted in the early months of pregnancy, it is associated with a high rate of serious birth defects such as deafness, cataracts, heart defects, and liver or spleen damage.

9. **Exclusion:** Yes, rubella is a highly communicable illness for which routine exclusion of infected children is warranted. For outbreaks, exclude exposed children who have not been immunized until they become immunized; or, if they are not immunized because of an accepted exemption, continue to exclude them until the health department determines it is safe for them to return. Unimmunized students need to be excluded until 21 days after the onset of the rash in the last case.

10. **Readmission:** Seven days after the onset of the rash and with clearance from the LACDPH or the licensed healthcare provider.

11. **Contacts and reporting:** Rubella is a reportable disease. Call the CD Desk if there is a need to report a **confirmed** case of rubella.

SCABIES

1. **What is scabies?** Scabies is an infestation of the skin with a microscopic mite. Scabies spread rapidly under crowded conditions where there is frequent skin-to-skin contact between people, such as in childcare facilities.

2. **What are the signs and symptoms of scabies?** Symptoms of scabies include pimple-like irritations, burrows, or rash of the skin, especially in the webbing between the fingers; the skin folds on the wrist, elbow, or knee; the penis; the breast; or the shoulder blades. Intense itching is common, especially at night. Sores can result from scratching and can sometimes become infected by bacteria. Children younger than 2 years are likely to be infested on the head, neck, palms, and soles of feet or in a diffuse distribution over the body.

3. **Incubation period:** 4 – 6 weeks for those who have never been infected; 1 – 4 days for those previously infested.

4. **Contagious period:** Until insect infestation is treated.

5. **How does infestation with scabies occur?** Scabies is spread to a healthy person by direct, prolonged, skin-to-skin contact with a person already infested with scabies. Infestation may also occur by sharing clothing, towels, and bedding. Infestation is easily spread to sexual partners and household members.

6. **How can infestation with scabies be prevented?** Health education regarding the cleanliness of persons, garments, and bedclothes and the need to be selective of intimate contacts can help prevent the spread of scabies. Having scabies once does not prevent one from becoming infected again since the body does not build up an immune response to scabies.

7. **Is there a treatment for scabies?** Several topical treatments, such as creams and lotions, are available to treat scabies. Even when treatment has eliminated the mites, itching may continue for 2-3 weeks, which does not mean one is still infested. No new burrows or rashes should appear 24-48 hours after effective treatment. Close contact(s) with the patient should be treated at the same time. Infested bedding and clothing should be laundered (in hot water), and items that cannot be laundered should be stored in a sealed plastic bag for at least 4 days.

8. **What are the circumstances in which scabies could be significant?** People with weakened immune systems, infants, and the elderly are at risk for a more severe form of scabies called Norwegian or crusted scabies.

9. **Exclusion:** Yes, at the end of the day, the child should consult a pediatric health professional and, if scabies is confirmed, the child should start treatment before returning. If treatment starts before the next day, no exclusion is necessary. Family members and close contacts to the infected individual should be treated at the same time, even if they have no signs or symptoms are present.

10. **Readmission:** After treatment has been completed (usually complete overnight).

11. **Contacts and reporting:** Informational letter should be sent to parent/guardian/teachers of all students in the affected classroom (Attachment G [English] or Anexo G-1 [Spanish], "Scabies Notification Letter," in BUL-1937.4, *Reporting Communicable Diseases*) with each identified case. Scabies is only reportable to the County in *atypical cases.* An atypical presentation involves heavy infestation with hundreds to thousands of mites, causing a crusted appearance. Crusted scabies is highly contagious because thousands of mites are imbedded in the thick crusts and easily shed in scales and flakes from affected skin. Call the CD Desk if there is a need to report an atypical (significantly infested and crusted) case.

SCARLET FEVER

1. **What is scarlet fever?** Scarlet fever is a rash that sometimes occurs in people with strep throat. Both scarlet fever and strep throat are caused by the same bacteria called group A streptococcus. The rash of scarlet fever is usually seen in children under the age of 18. Children who have scarlet fever are generally not any sicker than children with strep throat.

2. **What are the signs and symptoms of scarlet fever?** A rash first appears as tiny red bumps on the chest and abdomen. This rash may then spread all over the body. It looks like a sunburn and feels like a rough piece of sandpaper. It is usually redder in the armpits and groin areas. The rash lasts about 2-5 days. After the rash is gone, the skin on the tips of the fingers and toes often begins to peel. The face is flushed with a pale area around the lips. The throat is very red and sore and can have white or yellow patches. Fever, chills, swollen lymph nodes, and "strawberry tongue" can be seen. Other less common symptoms include nausea, vomiting, headache, and body aches.

3. **Incubation period:** 2 – 5 days.

4. **Contagious period:** The risk of spread is reduced when a person who is ill with strep throat is treated with antibiotics. Up to 25% of asymptomatic schoolchildren and a small number of adults carry the bacteria that cause strep throat in their nose and proportion of children with no symptoms of illness may be carriers. The risk of transmission from someone who is not sick but is carrying the bacteria is low.

5. **How does infection with scarlet fever occur?** The illness can be spread to an uninfected person through contact with the infected person's throat, mouth, and nasal fluids. Also, drinking from the same glass or sharing utensils with an infected person can spread the illness. Close contact helps the spread of the infection.

6. **How can infection with scarlet fever be prevented?** There is no vaccine against the bacteria that causes scarlet fever available currently. Thorough handwashing and avoiding contact with an infected person's throat, mouth, or nasal secretions are helpful prevention measures.

7. **Is there a treatment for scarlet fever?** A throat culture or rapid strep test is the only way to be certain of the diagnosis of strep throat. Scarlet fever can be treated with antibiotics. It is very important to finish the prescribed medication, even when symptoms subside, to prevent the development of complications or antibiotic-resistant bacteria.

8. **What are the circumstances in which scarlet fever can be significant?** If scarlet fever is not treated or prescribed antibiotics are not completed, rheumatic fever can occur in a small percentage of people. Rheumatic fever is a disease characterized by pain and swelling of tissues in various parts of the body and kidney problems.

9. **Exclusion:** Yes, until treatment has been initiated for 12 hours.

10. **Readmission:** At least the first 12 hours of antibiotic treatment has been given. Research has shown that children infected with strep do not pose a risk to others once they have received their first 12 hours of antibiotic treatment. When the child is able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

SHINGLES

1. **What are shingles?** An infection caused by the reactivation of varicella-zoster (chickenpox) virus within the body of someone who previously had chickenpox or, less commonly, someone who received the chickenpox vaccine in the past.

2. **What are the signs and symptoms of shingles?** Shingles symptoms usually affect only a small section on one side of your body. These symptoms may include pain, burning or tingling, sensitivity to touch, a red rash that begins a few days after the pain, fluid-filled blisters that break open and crust over, and itching. Some people also experience fever, headache, sensitivity to light, and fatigue. Pain is usually the first symptom of shingles. For some people, the pain can be intense. Depending on the location of the pain, it can sometimes be mistaken for problems with the heart, lungs, or kidneys. Some people experience shingles pain without ever developing the rash. Most commonly, the shingles rash develops as a stripe of blisters that wraps around either the left or right side of the torso. Sometimes, a shingles rash occurs around one eye or on one side of the neck or face.

3. **Incubation period:** The virus remains in the body in an inactive state for life after the original chickenpox infection. Shingles may occur when the virus (varicella zoster) reactivates many years after having chickenpox or the chickenpox vaccine.

4. **Contagious period:** Until the vesicles are covered by scabs.

5. **How does infection with shingles occur?** People develop shingles when the varicella-zoster virus, which causes chickenpox, reactivates in their bodies after they already have chickenpox. The virus in the shingles rash can spread by direct contact to a person who has never been vaccinated or had chickenpox. In this circumstance, the virus will cause chickenpox (not shingles) in that person.

6. **How can infection with shingles be prevented?** Vaccines can help lower the risk of shingles. Early treatment may shorten a shingles infection and lessen the chance of complications. Always use good hand-hygiene technique and be sure to cover the skin rash.

7. **Is there a treatment for shingles?** There is no cure for shingles. Early treatment with prescription antiviral drugs may speed healing and lower your risk of complications. These drugs include Acyclovir (Zovirax)**,** Famciclovir, and Valacyclovir (Valtrex). Shingles can cause severe pain, so your health care provider may also prescribe: Capsaicin topical patch (Qutenza)**;** Anticonvulsants, such as gabapentin (Neurontin, Gralise, Horizant)**;** Tricyclic antidepressants, such as amitriptyline**;** Numbing agents, such as lidocaine, in the form of a cream, gel, spray or skin patch**;** or an injection including corticosteroids and local anesthetics.

8. **What are the circumstances in which shingles can be significant?** The most common complication is postherpetic neuralgia. This is a painful condition that causes shingles pain for a long time after your blisters have cleared. Contact your health care provider as soon as possible if you suspect shingles, especially in the following situations: pain and rash occur near an eye. If left untreated, this infection may lead to permanent eye damage; age 50 or older as age increases your risk of complications; the affected individual or someone in the family has a weakened immune system (due to cancer, medications, or chronic illness); the rash is widespread and painful.

9. **Exclusion:** Students should stay home from school if the rash is still oozing fluid (weeping) and cannot be covered or until the rash has dried out. If able to, cover the rash with loose clothing or non-sticky dressing. If the student meets other exclusion criteria, they may be sent home.

10. **Readmission:** When rash can be covered or blisters have dried and scabbed over. If the rash cannot be fully covered, exclude children or staff with shingles from schools or childcare until all blisters have crusted.

STREP THROAT

1. **What is strep throat?** Strep throat is an infectious disease characterized by a sore throat. It is called "strep" after the bacterium that causes the infection (group A streptococcus).

2. **What are the signs and symptoms of strep throat?** Signs and symptoms of strep throat include: a sore throat that is red from inflammation, white patches on the tonsils or back of throat, swollen lymph nodes in the neck, fever, and headache. Children may also experience stomach pain, nausea, or vomiting. Strep throat is usually not accompanied by a stuffy nose or cough.

3. **Incubation period:** From 2 – 5 days.

4. **Contagious period:** The risk of spread is reduced when a person who is ill with strep throat is treated with antibiotics. Up to 25% of asymptomatic schoolchildren and a small number of adults carry the bacteria that cause strep throat in their nose and proportion of children with no symptoms of illness may be carriers. The risk of transmission from someone who is not sick but is carrying the bacteria is low.

5. **How does infection with strep throat occur?** The bacteria that cause strep throat are spread through direct contact with mucus from the nose or throat of persons who are infected or through contact with infected wounds or sores on the skin. Ill persons, such as those with strep throat or skin infections, are most likely to spread the infection. Persons who carry the bacteria but have no symptoms are much less contagious. Treating an infected person with an antibiotic for 24 hours or longer greatly decreases their ability to spread the bacteria.

6. **How can infection with strep throat be prevented?** Good hygienic measures, such as frequent hand washing and avoiding contact with mucus from an infected person, are the best prevention methods.

7. **Is there a treatment for strep throat?** Strep throat can be treated with antibiotics. A throat swab is usually needed to test for the infection and make the diagnosis. Finishing the prescribed medication to prevent complications or antibiotic-resistant bacteria is important, even when symptoms subside.

8. **What are the circumstances in which strep throat could be significant?** If strep throat is not treated or the prescribed course of antibiotics is not completed, rheumatic fever can occur in a small percentage of people. Rheumatic fever is a disease characterized by pain and swelling of tissues in various parts of the body and kidney problems. Other complications of strep throat can include ear infections, sinusitis and abscess in the tonsils.

9. **Exclusion:** Yes, until treatment has been initiated for 12 hours.

10. **Readmission:** After a minimum of 12 hours of antibiotic treatment. The untreated cases are excluded until clinical recovery, not less than 7 days. Research has shown that children infected with strep do not pose a risk to others once they have received their first 12 hours of antibiotic treatment. The student may be readmitted to school when they are able to participate and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

TUBERCULOSIS

1. **What is tuberculosis?** Tuberculosis (TB) is a disease caused by the bacterium *Mycobacterium tuberculosis* that classically affects the lungs. TB ***infection*** ("inactive" or "latent") is when a person has a positive TB skin test but no signs or symptoms of disease and a negative chest x-ray. Infected individuals are not contagious, but they may develop active TB disease at some time in the future. TB ***disease*** refers to those who have a positive TB skin test or an abnormal chest x-ray and may spread TB to others.

2. **What are the signs and symptoms of TB?** TB *infection* is without signs or symptoms. TB *disease* may cause a bad cough that lasts longer than 2 weeks (or chronic cough), chest pain, coughing up blood or phlegm, weakness or fatigue, weight loss, poor appetite, chills, fever, and night sweats.

3. **Incubation period:** 2 to 10 weeks after the initial infection. The risk of disease after infection is highest in the first 2 years, but the bacteria can be carried in the body for many years before active disease develops. Most infected people never develop active disease. They remain with latent infection.

4. **Contagious period:** Individuals with latent infection (do not have active disease) are not contagious. Generally, infants and children younger than 12 years with active TB disease are not contagious either. This is because they do not form cavities in their lungs with secretions that contain TB bacterium. When they cough, they do not create enough force to expel large numbers of TB germs into the air. Adults and some adolescents who have active TB spread the bacteria by coughing and contaminating the environment, which is how infants and young children can get infected. Usually, a person with active disease will remain contagious until treated.

5. **How does infection with TB occur?** The bacteria that cause TB are spewed into the air when a person with active TB coughs or sneezes. People nearby may breathe in these bacteria and become infected.

6. **How can infection with TB be prevented?** There is a vaccine for TB called BCG that is administered to infants and small children in countries where TB is common. The BCG vaccine does not always protect people from TB and is not recommended for routine use in the United States. Prevention of the progression from latent TB infection to active TB disease is usually accomplished through a course of an anti-tuberculosis drug. General public health measures are also instituted to prevent the spread of TB.

7. **Is there a treatment for TB?** Various anti-tuberculosis drugs are available for the treatment of TB disease. The entire course of drug treatment must be completed to prevent bacteria from becoming drug-resistant.

8. **What are the circumstances in which infection with TB could be significant?** TB can be fatal if left untreated. However, it can be prevented and controlled once contracted. It is important that the condition is diagnosed early in individuals with risk factors (i.e., HIV infection).

9. **Exclusion:** Yes, for persons with active TB *disease* who have not started appropriate therapy. *No* for persons with latent TB infection, whether they are receiving treatment or not.

10. **Readmission:** As soon as effective therapy has started, adherence to medication is documented, and the person is considered noninfectious. When the child or staff member is approved to return and considered noninfectious to others by local health officials. The LACDPH or CD Desk will notify the school of when a student is allowed to return after receiving treatment for active TB disease.

11. **Contacts and reporting:** Active Tuberculosis is reportable to LACDPH by the diagnosing health care provider. Contact investigation of TB disease will be performed according to the LACDPH policy. For any issue or question related to an active TB case, please contact the CD Desk.

WARTS

1. **What are warts?** Warts are non-cancerous skin growths caused by a viral infection in the top layer of the skin. Viruses that cause warts are called human papillomavirus (HPV). Common warts usually appear on the hands and feet, while genital warts appear in the genital area and are considered a sexually transmitted disease.

2. **What are the signs and symptoms of warts?** Warts are usually skin-colored and feel rough to touch, but they can be dark, flat, and smooth. There are a variety of types:
   - **Common warts** usually appear on the fingers and hands and are most frequently found where skin has been broken. These are often called "seed" warts because the blood vessels to the wart produce black dots that look like seeds. Most often, they are seen in young children.
   - **Plantar warts** are found on the soles of the feet. Most warts do not stick up, and it can be painful. Plantar warts are most commonly seen in school-age children and teenagers.
   - **Flat warts** are smaller and smoother than other warts. They tend to grow in large numbers (20-100 at a time) and are common on the face. Most often, they are seen in young children.
   - **Genital warts** are clusters of wart-like lesions in the genital area (vulva, vagina, anus, cervix, penis, scrotum, groin, or thigh). They usually occur as soft, moist, pink, or red swellings. They can be raised or flat, single or multiple, small or large. They can take weeks to months to appear after contact with an infected person.

3. **Incubation period:** Unknown but estimated at 3 months to several years.

4. **Contagious period:** As long as visible lesions are present (warts are only mildly contagious).

5. **How does infection with warts occur?** Person to person through close contact.

6. **How can infection with warts be prevented?** Perform hand hygiene after touching the warts. Do not share articles in contact with the warts of an infected child or educator. Do not scratch warts. Scratching could cause bacterial infection or spread of virus to other sites. The body may make antibodies to the virus so that, over time, the wart spontaneously resolves.

7. **Is there a treatment for warts?** Tissue-destructive treatments, such as medicated tape and liquid nitrogen, may activate the body's immune response to the virus that causes the wart and hasten resolution of the warts. However, treated warts may return and often require re-treatment. Although skin warts are caused by a viral infection, they are only mildly contagious. In children the skin wart virus most often spreads to other areas of the affected child's body rather than to other children. Warts do not need to be covered like shingles or other oozing sores. Treatment is a personal choice and is not required for infection control in an educational setting.

8. **What are the circumstances in which infection with warts could be significant?** Genital warts can cause cancer in the cervix, anus, and penis. Regular health check-ups, including Pap smears in women, are important to screen for pre-cancerous conditions and cervical cancers.

9. **Exclusion:** No.

10. **Readmission:** No restrictions.

PART IV:
UNCOMMON COMMUNICABLE DISEASES IN SCHOOL

CYTOMEGALOVIRUS INFECTION (CMV)

1. **What is CMV?** Cytomegalovirus (CMV) is a common virus that infects 50%-85% of adults in the United States by 40 years of age. CMV is the most common infection among those transmitted from a pregnant mother to her baby.

2. **What are the signs and symptoms of CMV?** For most healthy persons who acquire CMV after birth, there are few symptoms and no long-term health consequences. Some adolescents and adults may have a mononucleosis-like infection with a prolonged fever and mild hepatitis.

3. **Incubation period:** Unknown.

4. **Contagious period:** Unknown. The virus continues to be excreted in urine and saliva for months and sometimes years.

5. **How does infection with CMV occur?** Transmission of CMV occurs through various modes: close contact with a person excreting the virus in saliva, breast milk, urine, blood, and tears; sexual contact; blood transfusions; organ transplants; and from a mother to her baby before, during, and after birth. CMV has been shown to spread in households and daycare centers.

6. **How can infection with CMV be prevented?** Good personal hygiene is recommended to decrease the transmission of CMV. This includes care when handling children and items like soiled diapers, avoiding contact with oral secretions, and simple hand washing with soap and water, effectively removing the virus from the hands. This is especially important for women of childbearing age working with young children.

7. **Is there a treatment for CMV?** Treatment consists of an antiviral medication, which is used for certain patients, depending on age, disease, and mode of transmission. Treatment decisions are reserved for experienced health care professionals.

8. **Should children infected with CMV stay home from school to prevent spreading the disease?** CMV infection without symptoms is common in infants and children. There is no need to either screen or exclude CMV-excreting children from schools or institutions because the virus is frequently found in many healthy children and adults. Absence from school should only occur if symptoms are severe enough to prevent attendance.

9. **What are the circumstances in which CMV could be significant?** Infection can be significant in infants born to women whose first infection with CMV occurs during pregnancy. In addition, people with weak immune systems, such as organ transplant recipients and persons infected with HIV, may experience pneumonia, eye infections, gastrointestinal disease, or even death due to CMV. Hence, these groups should take extra hygienic precautions to prevent infection.

10. **Exclusion:** Generally, none for children with CMV, unless they meet other exclusion criteria (see “General Exclusion Criteria for Schools” page 6).

11. **Readmission:** When exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

GIARDIASIS

1. **What is Giardiasis?** The most common intestinal infection caused by a parasite (*Giardia duodenalis*) in the United States. This parasite is often found in streams, springs, ponds, lakes, and other natural bodies of water.

2. **What are the signs and symptoms of Giardiasis?**
   - Acute watery diarrhea
   - Excessive gas
   - Abdominal pain and cramps
   - Decreased appetite
   - Weight loss
   - Individuals can be infected and infectious without signs and symptoms.
   - The asymptomatic carrier state is more common in children than adults.
   - Some individuals may have symptoms that last for weeks to months.

3. **Incubation period:** 1 - 3 weeks after exposure.

4. **Contagious period:** Highly variable but can be months. Most contagious during diarrhea phase.

5. **How does infection with Giardia occur?** Giardia is caused by ingesting contaminated water or food, contamination of water supply by human or animal feces, and hand-to-mouth transfer of cysts from the feces of infected individuals. Individuals may contract the organism while drinking from streams or lakes while camping. Outbreaks can occur with contamination of the public water supply. Asymptomatic carriers are probably more important for spreading the disease than persons with active disease.

6. **How can infection with Giardia be prevented?** Practice careful and frequent handwashing, especially after using the toilet or changing soiled clothing. Identify and treat family members, staff, and children who have symptoms. Exclude people with diarrhea until they are symptom-free.
   Note: Treatment and exclusions of asymptomatic carriers are ineffective for outbreak control.

7. **Is there a treatment for Giardiasis?** Treatment generally consists of an anti-parasitic drug and correcting electrolyte imbalances or dehydration. Treatment for asymptomatic carriers is generally not recommended.

8. **Exclusion:** Yes, if diarrhea is present, the child is unable to participate, and/or the staff determines that they cannot care for the child without compromising their ability to care for the health and safety of the other children in the group. **Note:** For caregivers/teachers and children without symptoms (i.e., recently recovered or exposed), testing stool cultures, treatment, and exclusions is unnecessary.

9. **Readmission:** Once exclusion criteria (diarrhea) have been resolved.

10. **Contacts and reporting:** Giardiasis is a reportable disease to the LACDPH. Call the CD Desk if there is a need to report a *confirmed* case of Giardiasis.

HIV/AIDS

1. **What are HIV and AIDS?** Human immunodeficiency virus (HIV) is an infection that destroys the body's immune system and can cause a broad spectrum of diseases. Acquired immunodeficiency syndrome (AIDS) represents the most severe end of the clinical spectrum of HIV infection.

2. **What are the signs and symptoms of HIV and AIDS?** Children with HIV infection may show few signs or symptoms. Children with HIV infection may have:
   - Unexplained fevers.
   - Failure to grow and develop well.
   - Enlarged lymph nodes.
   - Swelling of salivary glands.
   - Enlargement of the liver and spleen.
   - Frequent infections, including pneumonia, diarrhea, and thrush (i.e., a yeast infection on the surfaces of the mouth).
   - Inflammation of the heart, salivary glands, liver, and kidneys.
   - Central nervous system disease.
   - Specific types of tumors.

3. **Incubation period:** If the infection is acquired before or during birth from infected mothers, children typically develop signs or symptoms between 12 and 18 months of age, although many remain symptom free for more than 5 years. With treatment, most children live into adulthood. However, approximately 15% to 20% of untreated children in the United States die before 4 years of age.

4. **Contagious period:** Infected individuals can transmit the virus in their body fluids throughout their lifetime.

5. **How does infection with HIV occur?** Contact of mucous membranes or openings in the skin with infected blood and body fluids that contain blood, semen, and cervical secretions; can also be spread from mother to baby through breastfeeding. If an infant has been mistakenly fed another infant's bottle of expressed human (breast) milk, the possible exposure to infectious disease should be treated just as if an unintentional exposure to other body fluids had occurred.
   - Contaminated needles or sharp instruments.
   - Mother–baby transmission before or during birth.
   - Sexual contact.
   - HIV is not spread by the type of contact that occurs in early childhood education (ECE) and school settings, such as in typical classroom activities or with surfaces touched by infected people. It is not spread through non-bloody saliva, tears, stool, or urine.

6. **How can infection with HIV be prevented?** Education on the methods of transmission of HIV is an important component of prevention. Prevention of HIV transmission by sexual contact can be accomplished by abstinence and safe sex practices such as the use of latex condoms. Universal precautions and standard procedures should be followed in the handling of potentially infectious material (see BUL-1645.3, *Infection Control Guidelines for Preventing the Spread of Communicable Diseases*, and *Bloodborne Pathogens Exposure Control Plan*).

7. **Is there a treatment for HIV or AIDS?** There is no cure or vaccine for HIV or AIDS currently. However, early intervention and treatment with antiretroviral drugs can slow the disease progression and prolong and improve the quality of life.

8. **What are the policies surrounding HIV/AIDS and school attendance?** A child or adult infected with HIV should not be isolated or excluded from any activity that their health status permits them to participate in. Their diagnosis of HIV/AIDS must remain confidential by law. Students and/or families are not required to disclose HIV infection status to anyone in the education system. No information regarding a person's HIV status will be divulged to any individual or organization without a Court Order or informed written, signed, and dated consent of the person with HIV infection (or the parent or guardian of a legal minor).

9. **Exclusion:** No unless the child meets other exclusion criteria (see "General Exclusion Criteria for Schools" page 6) or has bleeding problems or weeping skin lesions that cannot be covered. In such cases, school attendance will be decided on an individual basis, with consideration given to any risk for the infected person and any possible risk to others. Age, maturity level, physical condition, neurological development, behavior, psychological needs, and special environment or physical care requirements will be considered.

10. **Readmission:** Children who are known to be infected with HIV and have been excluded because of the risk of exposure to infections posed by group settings may return to school upon clearance from the child's health professional who is knowledgeable about HIV infection. Skin lesions must be dry and covered, and bleeding must be controlled. Complex cases of admission/readmission will be evaluated on an individual basis involving a collaborative decision-making process, which should include the school principal, family, and medical personnel.

11. **Contacts and reporting:** AIDS (cases meeting the criteria) is a reportable condition, but school personnel will generally not be involved with disease surveillance. Remember confidentiality of HIV/AIDS status is a legal requirement, and any questions regarding students with HIV/AIDS should be directed to the CD Desk.

LYME DISEASE

1. **What is Lyme disease?** An infection caused by a type of bacteria called a spirochete that is transmitted when particular types of ticks attach to a person's skin and feed on that person's blood.

2. **What are the signs and symptoms of Lyme disease?** Lyme disease can produce a wide range of symptoms, depending on the state of infection. These include fever, rash, facial paralysis, and arthritis.
   - Gradually expanding, large, circular or oval-shaped skin lesion (rash) with central clearing that appears after a tick bite. The individual lesion gets very large—usually 5 cm or greater in size. This lesion is present in children with early Lyme disease.
   - Fever.
   - Headache.
   - Mild neck stiffness.
   - Flu-like signs or symptoms.
   - Inability to move some of the muscles in the face (facial palsy).
   - Untreated Lyme disease usually resolves by itself, but a few infected people develop late Lyme disease with arthritis, neurologic problems, or meningitis.

3. **Incubation & Contagious period:** Incubation period: 1 to 32 days (usually around 11 days) from tick bite to appearance of rash. Lyme disease is not contagious except through blood transfusion or organ donation.

4. **How does infection with Lyme disease occur?** Infection occurs after a bite by a tick infected with Lyme disease bacteria (the tick usually must be attached for greater than 36 hours). Lyme disease cannot be spread from person to person (i.e., one cannot become infected from touching or kissing a person who has Lyme disease, from a health care worker who has treated someone with the disease, or by sexual contact).

5. **How can infection with Lyme disease be prevented?** The most effective measure of prevention is avoiding a tick bite. This can be aided by wearing appropriate clothing in tick-infested areas (e.g., tall grass, bushes, and wooded areas), daily tick checks, and quickly removing attached ticks. Insect repellants should be used on children only as directed by the manufacturer and according to Centers for Disease Control (CDC) instructions.

6. **Can a person be reinfected with Lyme disease?** Yes. Having had Lyme disease once does not protect against reinfection.

7. **Is there a treatment for Lyme disease?** Antibiotic treatment for 3-4 weeks is generally effective in early disease. Later, the disease may require intravenous antibiotics. In later disease treatment failures may occur, and retreatment may be necessary.

8. **What are the circumstances in which Lyme disease could be significant?** If Lyme disease is untreated, weeks to months after infection, some patients may develop arthritis, including intermittent swelling and pain in the large joints. Neurologic abnormalities such as meningitis and facial palsy may also occur. Rarely, heart problems, including an enlarged heart, can result.

9. **Exclusion:** None, unless they meet other exclusion criteria (see “General Exclusion Criteria for Schools” page 6).

10. **Readmission:** When exclusion criteria are resolved, the child is able to participate, and staff members determine they can care for the child without compromising their ability to care for the health and safety of the other children in the group.

11. **Contacts and reporting:** Lyme disease is a reportable disease. Call the CD Desk if there is a need to report a confirmed case of Lyme disease.

PINWORMS

1. **What are pinworms?** Pinworm refers to an infection caused by small, white, threadlike worms (0.25" – 0.5" long) that live in the large intestine. It has been estimated that 5%-15% of the U.S. population is infected, and higher rates are seen in preschool and school-aged children.

2. **What are the signs and symptoms of pinworms?** Children with pinworm infections have itching and irritation around the anal or vaginal area. Worms may be seen, especially after the child has been sleeping for a few hours, around the anus.

3. **Incubation period:** 1 to 2 months or longer from the time of ingesting the pinworm egg until an adult worm migrates to the anal area.

4. **Contagious period:** As long as the female worms are discharging eggs to the skin around the anus.

5. **How does infection with pinworms occur?** The transmission of pinworm eggs occurs by the fecal-oral route. This may occur directly or indirectly by coming in contact with contaminated toys, bedding, clothing, toilet seats, or baths. Pinworm eggs remain infective for 2 to 3 weeks in indoor environments, and infestations of pinworms commonly cluster within families.

6. **How can infection with pinworms be prevented?** Good hand hygiene is the most effective method of prevention. Parents may bathe the child in the morning to remove a large proportion of eggs laid at night and frequently change underwear, bedclothes, and bed sheets to decrease egg contamination. Wash toys frequently and clean and sanitize surfaces used for eating, toileting, food preparation, and diapering.

7. **Is there a treatment for pinworms?** Treatment with oral medication once or repeated in 2 weeks may be necessary for the whole family and the group of children who share a common environment.

8. **Exclusion:** No.

9. **Readmission:** No restrictions.

PART V:
BIOTERRORISM AND COMMUNICABLE DISEASE IN SCHOOLS

BIOTERRORISM

Since the September 11th attacks, there has been heightened concern and awareness of the use of biological agents in terrorist activities. This reference guide has already described some agents (e.g., food-borne illness, influenza). Still, the Centers for Disease Control and Prevention (CDC) has classified other, rarer agents as high priorities in the table below.

Category A **(Easily disseminated; high rates of mortality; may cause panic)**	**Category B** **(Moderately easy to disseminate; moderate rates of morbidity and low mortality)**
Anthrax	Q fever
Smallpox	Brucellosis
Plague	Eastern/western equine encephalitis
Tularemia	Ricin toxin
Botulism	Clostridia toxin
Viral Hemorrhagic Fevers (e.g., Ebola)	Food and water-borne illness (e.g., Salmonella, Shigella, E. Coli O157:H7)

Children may be particularly vulnerable to a bioterrorist attack compared to adults. This is due to their higher respiratory rate, increased skin absorption, high surface (skin) to volume (weight) ratio, and the general crowded conditions of schools and childcare centers. The symptoms of illness caused by bioterrorism agents are similar to symptoms of other common infectious diseases (e.g., fever, headache, vomiting, and diarrhea). Furthermore, the symptoms may not be evident immediately upon exposure to the infectious agent. It may be difficult to distinguish between intentional infection and a naturally occurring outbreak.

Many children spend much of their day in schools, supervised by teachers, administrators, and health professionals. This makes the school a good place to monitor unusual signs and symptoms or recognize patterns of illness occurring in a greater-than-average number of students (or staff). Schools have become increasingly prepared for disasters, and there are policies to guide schools in, crisis intervention (See BUL-5800.1, *Crisis Preparedness, Response and Recovery*, dated July 31, 2023). As part of the many first-line responders, school staff and District health professionals should have a basic understanding of bioterrorism and the agents that may cause immediate and significant harm.

The following table describes some early signs and symptoms that may help distinguish the CDC's Category A and B biologic agents. Complete descriptions of each agent can be found using the links to CDC fact sheets available on the CDC website: About Chemical Emergencies | Chemical Emergencies | CDC.

Prominent Early Clinical Manifestations after Exposure to Bioterrorist Agents

Early Clinical Manifestations	Agents/Disease	Links to more information
Respiratory		
Flu-like illness with or without atypical pneumonia (seen on chest radiograph)	Tularemia Brucellosis Q fever	Signs and Symptoms of Tularemia | Tularemia | CDC About Brucellosis | Brucellosis | CDC Signs and Symptoms of Q fever | Q Fever | CDC
Flu-like illness with cough and difficulty breathing	Anthrax (inhalational) Plague (pneumonic) Tularemia (inhalational) Ricin Hantavirus	About Anthrax | Anthrax | CDC Signs and Symptoms of Plague | Plague | CDC About Tularemia | Tularemia | CDC https://emergency.cdc.gov/agent/ricin/facts.asp About Hantavirus | Hantavirus | CDC
Sore throat (with pus) and swollen lymph nodes (neck)	Tularemia (oropharyngeal)	Signs and Symptoms of Tularemia | Tularemia | CDC
Dermatologic		
Small red spots in the mouth, progressing to vesicular rash (fluid-filled bubbles), fever, headache, and malaise	Smallpox	About Smallpox | Smallpox | CDC
A small sore that develops into blister, then a black ulcer (all are painless)	Anthrax (cutaneous)	About Anthrax | Anthrax | CDC
Ulcers to the skin and mouth; painful, swollen glands and flu-like illness	Tularemia (ulceroglandular)	Signs and Symptoms of Tularemia | Tularemia | CDC
Small purple spots (petechiae) with fever and weakness	Viral hemorrhagic fever	About Viral Hemorrhagic Fevers | Viral Hemorrhagic Fevers (VHFs) | CDC
Cardiovascular		
Shock and difficulty breathing	Anthrax (inhalational) Ricin Viral hemorrhagic fever	About Anthrax | Anthrax | CDC https://emergency.cdc.gov/agent/ricin/facts.asp About Viral Hemorrhagic Fevers | Viral Hemorrhagic Fevers (VHFs) | CDC

Early Clinical Manifestations	Agents/Disease	Links to more information
Neurologic		
Blurred vision; slurred speech; (descending) muscle weakness progressing to flaccid paralysis	Botulism	About Botulism | Botulism | CDC
Headache, dizziness, nervous system malfunction; seizures; coma	Anthrax (inhalational) Plague (septicemic and pneumonic)	About Anthrax | Anthrax | CDC About Plague | Plague | CDC
Gastrointestinal		
Diarrhea	*Salmonella species* *Shigella dysenteriae* *E. Coli* O157:H7 *Vibrio cholerae* Cryptosporidium	About Salmonella Infection | Salmonella Infection | CDC About Shigella Infection | Shigella - Shigellosis | CDC About Escherichia coli Infection | E. coli infection | CDC About Cholera | Cholera | CDC About Crypto Infections | Cryptosporidium ("Crypto") | CDC
Vomiting, abdominal pain, bloody diarrhea	Anthrax (gastrointestinal)	About Anthrax | Anthrax | CDC
Renal/Kidneys		
Blood clotting problem; renal Failure	*E. Coli* O157:H7 *Shigella dysenteriae*	About Escherichia coli Infection | E. coli infection | CDC About Shigella Infection | Shigella - Shigellosis | CDC
Renal failure, no urine output	Viral hemorrhagic fever Hantavirus	About Viral Hemorrhagic Fevers | Viral Hemorrhagic Fevers (VHFs) | CDC About Hantavirus | Hantavirus | CDC
Other		
Painful, swollen glands (lymph nodes)	Plague (bubonic)	Signs and Symptoms of Plague | Plague | CDC
Red and inflamed eyes with pus (conjunctivitis); swollen glands in the neck and in front of the ears	Tularemia (oropharyngeal)	About Tularemia | Tularemia | CDC

Adapted from CDC Website, 1/10/2025

PART VI:
APPENDICES

APPENDIX A:
COUNTY OF LOS ANGELES REPORTABLE DISEASES AND CONDITIONS

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REPORTABLE DISEASES AND CONDITIONS

Title 17, California Code of Regulations (CCR), § 2500

It is the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. "Health care provider" encompasses physicians (surgeons, osteopaths, oriental medicine practitioners), veterinarians, podiatrists, physician assistants, registered nurses (nurse practitioners, nurse midwives, school nurses), infection control professionals, medical examiners/coroners, dentists, and chiropractors, as well as any other person with knowledge of a case or suspected case. **All reports must include hospitalization status if known.**

Note: This list is specific to Los Angeles County and differs from state and federal reporting requirements ★

☎ Report **immediately** by telephone for both confirmed and suspected cases.
❶ Report by telephone **within 1 working day** from identification.
❷ Report by telephone **within 24 hours** for both confirmed and suspected cases.
✉ Report by electronic transmission (including FAX or email), telephone or mail within **1 working day** from identification.
⑦ Report by electronic transmission (including FAX or email), telephone or mail within **7 calendar days** from identification.
★ Mandated by and reportable to the Los Angeles County Department of Public Health.
± If enrolled, report electronically via the **National Healthcare Safety Network** (www.cdc.gov/nhsn/index.html). If not enrolled, use the LAC DPH **CRE Case Report Form** (publichealth.lacounty.gov/acd/Diseases/EpiForms/CRERepSNF.pdf)
■ For TB reporting: contact the TB Control Program (213) 745-0800 or visit www.publichealth.lacounty.gov/tb/healthpro.htm
■ For HIV/STD reporting: contact the Division of HIV and STD Programs. HIV (213) 351-8516, STDs (213) 368-7441 www.publichealth.lacounty.gov/dhsp/ReportCase.htm

For laboratory reporting: www.publichealth.lacounty.gov/lab/index.htm **For veterinary reporting**: www.publichealth.lacounty.gov/vet/index.htm

REPORTABLE COMMUNICABLE DISEASES

⑦ Anaplasmosis
☎ Anthrax, human or animal
✉ Babesiosis
☎ Botulism, foodborne or wound
☎ Botulism, infant—Reportable to CDPH IBTPP (see below±)
⑦ Brucellosis, animal; except infections due to *Brucella canis*
✉ Brucellosis, human
✉ Campylobacteriosis
✉ *Candida auris*, colonization or infection
⑦ Carbapenem-Resistant *Enterobacteriaceae* (CRE), including *Klebsiella sp., E. coli,* and *Enterobacter sp.*, in acute care hospitals or skilled nursing facilities ★±
⑦ Chagas Disease ★
⑦ Chancroid ■
✉ Chickenpox (Varicella), only hospitalizations, deaths, and outbreaks (≥3 cases, or one case in a high-risk setting)
✉ Chikungunya Virus Infection
☎ Cholera
☎ Ciguatera Fish Poisoning
⑦ Coccidioidomycosis
✉ COVID-19 hospitalizations (Inpatient reporting instructions)
⑦ Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
❷ Cronobacter, Invasive Infection among Infants
✉ Cryptosporidiosis
✉ Cyclosporiasis
⑦ Cysticercosis or Taeniasis
⑦ Cytomegalovirus, congenital ★
✉ Dengue Virus Infection
☎ Diphtheria
☎ Domoic Acid (Amnesic Shellfish) Poisoning
⑦ Ehrlichiosis
✉ Encephalitis, specify etiology: viral, bacterial, fungal or parasitic
✉ *Escherichia coli*, shiga toxin producing (STEC) including *E. coli* O157
☎ Flavivirus infection of undetermined species
✉ Foodborne Disease
☎ Foodborne Outbreak; 2 or more suspected cases from separate households with same assumed source
⑦ Giardiasis
⑦ Gonococcal Infection ■
✉ *Haemophilus influenzae*, invasive disease only, all serotypes, less than 5 years of age
✉ Hantavirus Infection
✉ Hemolytic Uremic Syndrome
✉ Hepatitis A, acute infection
⑦ Hepatitis B, specify acute, chronic, or perinatal
⑦ Hepatitis C, specify acute, chronic, or perinatal
⑦ Hepatitis D (Delta), specify acute or chronic
⑦ Hepatitis E, acute infection
❶ Human Immunodeficiency Virus (HIV), acute infection ■ (§2641.30-2643.20)
⑦ Human Immunodeficiency Virus (HIV) infection, any stage ■*
⑦ Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS) ■*
⑦ Influenza-associated deaths in laboratory confirmed cases, <18 years of age
☎ Influenza, due to novel strains, human
✉ Legionellosis
⑦ Leprosy (Hansen's Disease)
⑦ Leptospirosis
✉ Listeriosis
⑦ Lyme Disease
✉ Malaria
☎ Measles (Rubeola)
☎ Melioidosis
✉ Meningitis, specify etiology: viral, bacterial, fungal, or parasitic
☎ Middle East Respiratory Syndrome (MERS)
✉ Mpox or Orthopox virus infections, hospitalizations, and deaths (Online reporting)
✉ Multisystem Inflammatory Syndrome in Children (MIS-C)
⑦ Mumps
❷ Myelitis, acute flaccid ★
☎ *Neisseria meningitidis* (invasive disease)
⑦ Nontuberculosis mycobacteria (extrapulmonary) ★
☎ Novel virus infection with pandemic potential
☎ Paralytic Shellfish Poisoning
✉ Paratyphoid Fever
✉ Pertussis (Whooping Cough)
☎ Plague, human or animal
❷ Poliovirus Infection
✉ Psittacosis
✉ Q Fever
☎ Rabies, human or animal
✉ Relapsing Fever
⑦ Respiratory Syncytial Virus, only deaths in a patient less than 5 years of age
⑦ Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
⑦ Rocky Mountain Spotted Fever
⑦ Rubella (German Measles)
⑦ Rubella Syndrome, Congenital
✉ Salmonellosis, other than Typhoid Fever
☎ Scombroid Fish Poisoning
✉ Shiga toxin, detected in feces
✉ Shigellosis
⑦ Silicosis
☎ Smallpox (Variola)
✉ *Streptococcus pneumoniae*: Invasive cases only (sterile body site infections) ★
✉ *Streptococcus pyogenes* (Group A *Streptococcus*): Invasive cases only, including necrotizing fasciitis and STSS ★
✉ Syphilis, all stages including congenital ■
⑦ Tetanus
✉ Trichinosis
✉ Tuberculosis ■
⑦ Tularemia, animal
☎ Tularemia, human
✉ Typhoid Fever, cases and carriers
✉ *Vibrio* Infection
☎ Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)
✉ West Nile Virus (WNV) Infection
✉ Yellow Fever
✉ Yersiniosis
✉ Zika Virus Infection
☎ **OCCURRENCE OF ANY UNUSUAL DISEASE**
☎ **OUTBREAKS OF ANY DISEASE**, including diseases not listed above. Specify if in an institution and/or the open community.

± Suspected infant botulism should be reported immediately by phone to CDPH IBTPP (510-231-7600)

* *Use of FAX for HIV reporting is highly discouraged in order to protect patient confidentiality.*

REPORTABLE NON-COMMUNICABLE DISEASES OR CONDITIONS

☎ Animal (mammal) bites to humans (CCR § 2606) immediate electronic report ⑦ Cancer, including benign and borderline brain tumors (CCR § 2593)
⑦ Disorders Characterized by Lapses of Consciousness (CCR § 2806, § 2810) ✉ Pesticide-Related Illnesses (Health and Safety Code § 105200)

To report a case or outbreak of any disease, contact the Communicable Disease Reporting System
Tel: (888) 397-3993 or (213) 240-7821 (M-F 8am-5pm) • **(213) 974-1234** (afterhours, weekends, holidays)
Fax: (888) 397-3778 or (213) 482-5508 • Email: RPU@ph.lacounty.gov
Health Professionals Reporting Webpage: www.publichealth.lacounty.gov/clinicians/report

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REPORTABLE DISEASES AND CONDITIONS

Title 17, California Code of Regulations (CCR), § 2500

It is the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. "Health care provider" encompasses physicians (surgeons, osteopaths, oriental medicine practitioners), veterinarians, podiatrists, physician assistants, registered nurses (nurse practitioners, nurse midwives, school nurses), infection control professionals, medical examiners/coroners, dentists, and chiropractors, as well as any other person with knowledge of a case or suspected case. **All reports must include hospitalization status if known.**

Note: This list is specific to Los Angeles County and differs from state and federal reporting requirements ★

☎ Report immediately by telephone (for both confirmed and suspected cases)

OCCURRENCE OF ANY UNUSUAL DISEASE OUTBREAKS OF ANY DISEASE, including diseases not otherwise listed. Specify if in an institution and/or the open community.

- Anthrax, human or animal
- Botulism, foodborne or wound
- Botulism, infant (*report immediately by phone to CDPH IBTPP 510-231-7600)*
- Cholera
- Ciguatera Fish Poisoning
- Diphtheria
- Domoic Acid (Amnesic Shellfish) Poisoning
- Flavivirus infection of undetermined species
- Foodborne Outbreak; 2 or more suspected cases from separate households with same assumed source
- Influenza, due to novel strains, human
- Measles (Rubeola)
- Middle East Respiratory Syndrome (MERS)
- Melioidosis
- *Neisseria meningitidis* (invasive disease)
- Novel virus infection with pandemic potential
- Paralytic Shellfish Poisoning
- Plague, human or animal
- Rabies, human or animal
- Scombroid Fish Poisoning
- Smallpox (Variola)
- Tularemia, human
- Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)

Animal (mammal) bites to humans (CCR§ 2606) immediate electronic report

❶ Human Immunodeficiency Virus (HIV), acute infection (Telephone within 1 working day)

⑦ Report within 24 hours by telephone for both confirmed and suspected cases

Cronobacter, Invasive Infection among Infants

Poliovirus Infection

Myelitis, acute flaccid ★

✉ Report by electronic transmission (including FAX or email), telephone or mail within 1 working day from identification

- Babesiosis
- Brucellosis
- Campylobacteriosis
- *Candida auris*, colonization or infection
- Chickenpox (Varicella), only hospitalizations, deaths, and outbreaks (≥3 cases, or one case in a high-risk setting)
- Chikungunya Virus Infection
- COVID-19, hospitalizations (Inpatient reporting instructions)
- Cryptosporidiosis
- Cyclosporiasis
- Dengue Virus Infection
- Encephalitis, specify etiology: viral, bacterial, fungal or parasitic
- *Escherichia coli*, shiga toxin producing (STEC) including *E. coli* O157
- Foodborne Disease
- *Haemophilus influenzae*, invasive disease only, all serotypes, less than 5 years of age
- Hantavirus Infection
- Hemolytic Uremic Syndrome
- Hepatitis A, acute infection
- Legionellosis
- Listeriosis
- Malaria
- Meningitis, specify etiology: viral, bacterial, fungal, or parasitic
- Mpox or Orthopox virus infections, hospitalizations, and deaths (Online reporting)
- Multisystem Inflammatory Syndrome in Children (MIS-C)
- Paratyphoid Fever
- Pertussis (Whooping Cough)
- Pesticide-Related Illnesses (Health and Safety Code §105200)
- Psittacosis
- Q Fever
- Relapsing Fever
- Salmonellosis, other than Typhoid Fever
- Shiga toxin, detected in feces
- Shigellosis
- *Streptococcus pneumoniae*: Invasive cases only (sterile body site infections) ★
- *Streptococcus pyogenes* (Group A *Streptococcus*): Invasive cases only, including necrotizing fasciitis and STSS ★
- Syphilis, all stages including congenital
- Trichinosis
- Tuberculosis
- Typhoid Fever, cases and carriers
- *Vibrio* Infection
- West Nile Virus (WNV) Infection
- Yellow Fever
- Yersiniosis
- Zika Virus Infection

⑦ Report by electronic transmission (including FAX or email), telephone or mail within 7 calendar days from identification

- Anaplasmosis
- Brucellosis, animal; except infections due to *Brucella canis*
- Cancer, including benign and borderline brain tumors (CCR §2593)*
- Carbapenem-Resistant *Enterobacteriaceae* (CRE), including *Klebsiella sp., E. coli,* and *Enterobacter sp.*, in acute care hospitals or skilled nursing facilities ★±
- Chagas Disease ★
- Chancroid
- Coccidioidomycosis
- Creutzfeldt-Jakob Disease and other Transmissible Spongiform Encephalopathies
- Cysticercosis or Taeniasis
- Cytomegalovirus, congenital ★
- Disorders Characterized by Lapses of Consciousness (CCR § 2806, § 2810)
- Ehrlichiosis
- Giardiasis
- Gonococcal Infection
- Hepatitis B, specify acute, chronic, or perinatal
- Hepatitis C, specify acute, chronic, or perinatal
- Hepatitis D (Delta), specify acute or chronic
- Hepatitis E, acute infection
- Human Immunodeficiency Virus (HIV) infection, any stage **
- Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS) **
- Influenza-associated deaths in laboratory confirmed cases, <18 years of age
- Leprosy (Hansen's Disease)
- Leptospirosis
- Lyme Disease
- Mumps
- Nontuberculosis mycobacteria (extrapulmonary) ★
- Respiratory Syncytial Virus, only deaths in a patient less than 5 years of age
- Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- Silicosis
- Tetanus
- Tularemia, animal

*Except basal and squamous skin cancer unless on genital, and carcinoma in-situ and CIN III of the Cervix.

***Use of FAX for **HIV reporting** is highly discouraged in order to protect patient confidentiality.*

± If enrolled, report electronically via the **National Healthcare Safety Network.**
If not enrolled, use the LACDPH CRE Case Report Form

To report a case or outbreak of any disease, contact the Communicable Disease Reporting System
Tel: (888) 397-3993 or (213) 240-7821 (M-F 8am-5pm) • **(213) 974-1234** (afterhours, weekends, holidays)
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Health Professionals Reporting Webpage: www.publichealth.lacounty.gov/clinicians/report

APPENDIX B:
CALIFORNIA IMMUNIZATION REQUIREMENTS FOR TK-12 SCHOOLS

California Immunization Requirements for

K–12th Grade (including transitional kindergarten)

CDPH California Department of Public Health

Grade	Number of Doses Required of Each Immunization[1, 2, 3]					
K-12 Admission	4 Polio[4]		5 DTaP[5]	3 Hep B[6]	2 MMR[7]	2 Varicella
(7th-12th)[8]	K-12 doses	+	1 Tdap			
7th Grade Advancement[9,10]			1 Tdap[8]			

1. Requirements for K-12 admission also apply to transfer pupils.
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. Three doses of polio vaccine meet the requirement if one dose was given on or after the 4th birthday. Oral polio vaccine (OPV) doses given on or after April 1, 2016, do not count.
5. Four doses of DTaP meet the requirement if at least one dose was given on or after the 4th birthday. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the 7th birthday (also meets the 7th-12th grade Tdap requirement: see fn. 8). One or two doses of Td vaccine given on or after the 7th birthday count towards the K-12 requirement.
6. For 7th grade admission, refer to Health and Safety Code section 120335, subdivision (c).
7. Two doses of measles, two doses of mumps, and one dose of rubella vaccine meet the requirement, separately or combined. Only doses administered on or after the 1st birthday meet the requirement.
8. For 7th-12th graders, at least one dose of pertussis- containing vaccine is required on or after the 7th birthday.
9. For children in ungraded schools, pupils 12 years and older are subject to the 7th grade advancement requirements.
10. The prior 2-dose varicella requirement for 7th grade advancement expired June 30, 2025.

DTaP/Tdap = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine
Varicella = chickenpox vaccine

Instructions:

California schools are required to check immunization records for all new student admissions at TK/ Kindergarten through 12th grade and all students advancing to 7th grade before entry. See shotsforschool.org for more information.

Unconditionally Admit a pupil whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age or grade as defined in the table above:

- Receipt of immunization.
- A permanent medical exemption. *

Conditionally Admit any pupil who lacks documentation for unconditional admission if the pupil has:

- Commenced receiving doses of all the vaccines required for the pupil's grade (table above) and is not currently due for any doses at the time of admission (as determined by intervals listed in the Conditional Admission Schedule, column entitled "Exclude If Not Given By"), or
- A temporary medical exemption from some or all required immunizations. *

Conditional Admission Schedule for Grades K-12

Before admission a child must obtain the first dose of each required vaccine and any subsequent doses that are due because the period of time allowed before exclusion has elapsed.

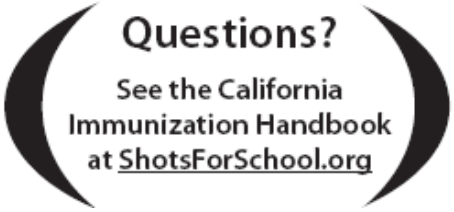
Dose	Earliest Dose May Be Given	Exclude If Not Given By
Polio #2	4 weeks after 1st dose	8 weeks after 1st dose
Polio #3[1]	4 weeks after 2nd dose	12 months after 2nd dose
Polio #4[1]	6 months after 3rd dose	12 months after 3rd dose
DTaP #2	4 weeks after 1st dose	8 weeks after 1st dose
DTaP #3[2]	4 weeks after 2nd dose	8 weeks after 2nd dose
DTaP #4	6 months after 3rd dose	12 months after 3rd dose
DTaP #5	6 months after 4th dose	12 months after 4th dose
Hep B #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #3	8 weeks after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose
MMR #2	4 weeks after 1st dose	4 months after 1st dose
Varicella #2	Age less than 13 years: 3 months after 1st dose	4 months after 1st dose
Varicella #2	Age 13 years and older: 4 weeks after 1st dose	8 weeks after 1st dose

1. Three doses of polio vaccine meet the requirement if one dose was given on or after the fourth birthday. If polio #3 is the final required dose, polio #3 should be given at least six months after polio #2.
2. If DTaP #3 is the final required dose, DTaP #3 should be given at least six months after DTaP #2, and pupils should be excluded if not given 12 months after second dose. Three doses meet the requirement if at least one dose of Tdap, DTaP, or DTP vaccine was given on or after the seventh birthday. One or two doses of Td vaccine given on or after the seventh birthday count towards the requirement.

Continued attendance after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The school shall:

- review records of any pupil admitted conditionally to a school at least every 30 days from the date of admission,
- inform the parent or guardian of the remaining required vaccine doses until all required immunizations are received or an exemption is filed, and
- update the immunization information in the pupil's record.

For a pupil transferring from another school in the United States whose immunization record has not been received by the new school at the time of admission, the school may admit the child for up to 30 school days. If the immunization record has not been received at the end of this period, the school shall exclude the pupil until the parent or guardian provides documentation of compliance with the requirements.



* In accordance with 17 CCR sections 6050-6051 and Health and Safety Code sections 120370-120372.

California Immunization Requirements for

Pre-Kindergarten

(any private or public child care center, day nursery, nursery school, family day care home, or development center)

Doses required by age when admitted and at each age checkpoint after entry[1]:

Age When Admitted	Total Number of Doses Required of Each Immunization[2,3]				
2 through 3 months	**1 Polio**	**1 DTaP**	**1 Hep B**	**1 Hib**	
4 through 5 months	**2 Polio**	**2 DTaP**	**2 Hep B**	**2 Hib**	
6 through 14 months	**2 Polio**	**3 DTaP**	**2 Hep B**	**2 Hib**	
15 through 17 months	**3 Polio**	**3 DTaP**	**2 Hep B**		**1 Varicella**
	On or after the 1st birthday:			**1 Hib[4]**	**1 MMR**
18 months through 5 years	**3 Polio**	**4 DTaP**	**3 Hep B**		**1 Varicella**
	On or after the 1st birthday:			**1 Hib[4]**	**1 MMR**

1. A pupil's parent or guardian must provide documentation of a pupil's proof of immunization to the governing authority no more than 30 days after a pupil becomes subject to any additional requirement(s) based on age, as indicated in the table above (Table A).
2. Combination vaccines (e.g., MMRV) meet the requirements for individual component vaccines. Doses of DTP count towards the DTaP requirement.
3. Any vaccine administered four or fewer days prior to the minimum required age is valid.
4. One Hib dose must be given on or after the first birthday regardless of previous doses. Required only for children who have not reached the age of five years.

Polio = inactivated polio vaccine (IPV) (oral polio vaccine [OPV] does not count)
DTaP = diphtheria toxoid, tetanus toxoid, and acellular pertussis vaccine
Hib = Haemophilus influenzae, type B vaccine Hep B = hepatitis B vaccine
MMR = measles, mumps, and rubella vaccine Varicella = chickenpox vaccine

Instructions:

California pre-kindergarten (child care or preschool) facilities are required to check immunizations for all new admissions and at each age checkpoint.

Unconditionally Admit a pupil age 18 months or older whose parent or guardian has provided documentation of any of the following for each immunization required for the pupil's age as defined in the table above:

- Receipt of immunization.
- A permanent medical exemption. *

Conditional Admission Schedule for Pre-Kindergarten

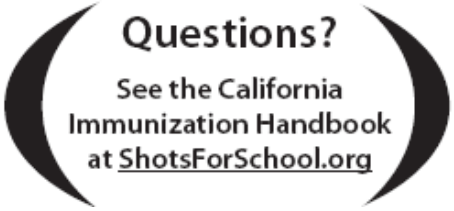
Before admission a child must obtain the first dose of each required vaccine and any subsequent doses that are due because the period of time allowed before exclusion has elapsed.

Dose	Earliest Dose May Be Given	Exclude If Not Given By
Polio #2	4 weeks after 1st dose	8 weeks after 1st dose
Polio #3	4 weeks after 2nd dose	12 months after 2nd dose
DTaP #2, #3	4 weeks after previous dose	8 weeks after previous dose
DTaP #4	6 months after 3rd dose	12 months after 3rd dose
Hib #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #2	4 weeks after 1st dose	8 weeks after 1st dose
Hep B #3	8 weeks after 2nd dose and at least 4 months after 1st dose	12 months after 2nd dose

Conditionally Admit any pupil who lacks documentation for unconditional admission if the pupil:

- has commenced receiving doses of all the vaccines required for the pupil's age (table on page 1) and is not currently due for any doses at the time of admission (as determined by intervals listed in the Conditional Admission Schedule, column entitled "EXCLUDE IF NOT GIVEN BY"), or
- is younger than 18 months and has received all the immunizations required for the pupil's age (table on page 1) but will require additional vaccine doses at an older age (i.e., at next age checkpoint), or
- has a temporary medical exemption from some or all required immunizations.*

Continued attendance after conditional admission is contingent upon documentation of receipt of the remaining required immunizations. The pre-kindergarten facility shall notify the pupil's parent or guardian of the date by which the pupil must complete all remaining doses.



* In accordance with 17 CCR sections 6050-6051 and Health and Safety Code sections 120370-120372.

APPENDIX C:
REFERENCES

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BUL-1660.10, *Immunization Guidelines for School Admission*, December 2, 2024.

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