

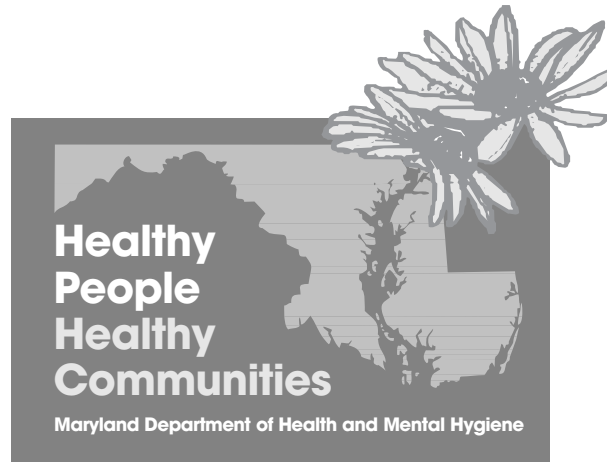
COMMUNICABLE DISEASE SUMMARY

Guide for Schools and Child Care Settings



Maryland Department of Health and Mental Hygiene
Community and Public Health Administration
Epidemiology and Disease Control Program

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Maryland Department of Health and Mental Hygiene
Community and Public Health Administration
Epidemiology and Disease Control Program
201 West Preston Street
Baltimore, MD 21201
410-767-6700

Parris N. Glendening
Governor

Martin P. Wasserman, M.D., J.D.
Secretary

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<http://www.dhmh.state.md.us>

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Communicable Diseases Summary: Guide for Schools and Child Care Settings

Disease	Incubation Period	Symptoms	Mode of Transmission	Period of Communicability	Control Measures and Period of Exclusion†	Other Information
CHICKENPOX (Varicella)	10 to 21 days, usually 13 to 17 days.	Sudden onset of slight fever and skin rash consisting of small blisters lasting 3 to 4 days that develop into crusts which last about 14 days. The eruptions come out in crops, so there may be pimples, blisters, and scabs present at the same time.	Person-to-person by direct contact, airborne spread of respiratory secretions; indirectly through contact with articles freshly soiled with secretions from nose, throat, and skin lesions. The fluid from the blisters is infective; scabs are not.	Usually 1 to 2 days before onset of rash to 5 days after the first crop of blisters.	Exclude case until blisters are dry and crusted, or 5 days after first crop of blisters appear, whichever is shorter. Pregnant women exposed to chickenpox or shingles should consult with their doctor. No exclusion for shingles if lesions can be covered until crusted. "High risk" persons exposed to chickenpox may need VZIG.	Babies exposed when less than 2 days old to mothers with varicella and persons with immunodeficiency may suffer severe or fatal chickenpox. Shingles (herpes zoster) is a reactivation of the same virus. Varicella vaccine is required for new child care enrollees born on or after 1/1/97 in September 1998 and will be required for school entry beginning with Pre-K in September 2000.
COMMON COLD	12 to 72 hours, usually 2 days.	Runny nose, watery eyes, sneezing, chills, sore throat, cough, and general body discomfort lasting 2 to 7 days.	Person-to-person by direct contact or airborne droplets; indirect contact with articles freshly soiled with secretions from nose and throat of an infected person.	Variable depending on cause; average is 7 to 10 days.	Routine exclusion is not recommended. Stress personal hygiene, e.g., cover mouth and nose when coughing/sneezing; practice sanitary disposal of discharges from mouth and nose; encourage frequent hand washing; etc.	Rhinoviruses and coronaviruses are the major known viral cause of colds in adults. Cold-like illnesses in infants and children are caused by viruses such as parainfluenza, RSV, influenza, and adenoviruses.
CONJUNCTIVITIS (Pink eye)	Varies depending on causative agent.	Pink or red conjunctiva with white or yellow eye discharge, often with matted eyelids after sleep; eye pain; swelling or redness of the eyelids or skin around the eye.	Respiratory or conjunctival secretions via person-to-person contact; direct contact through contamination of the hands; contact with articles soiled with secretions from the nose and throat of an infected person, e.g., shared towels; rarely via contaminated swimming pools.	Varies depending on causative agent.	Exclude case until cleared by a physician, until on antibiotics for 24 hours if indicated, or until symptoms have resolved, whichever is earlier. Pink eye with only clear, watery eye discharge and without eyelid redness need not be excluded. Practice frequent hand washing and hygiene.	Newborns with conjunctivitis should be referred to a physician.

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DIARRHEAL DISEASES/ GASTROENTERITIS (for example, <i>E. coli</i> O157:H7*, <i>Giardia</i> , <i>Salmonella</i> *, <i>Shigella</i> *, viruses such as rotavirus or Norwalk agent)	Varies depending on causative agent.	Loose stools (diarrhea) which may be accompanied by vomiting, nausea, headache, abdominal cramps, or fever. May have blood in stools.	Person-to-person contact, often by fecal contamination; by ingestion of food or water contaminated with bacteria, viruses, or parasites, e.g., food poisoning.	Varies depending on causative agent.	Exclude case until 24 hours after vomiting and diarrhea ends if illness is not caused by <i>Salmonella</i> , <i>Shigella</i> , or <i>E. coli</i> O157:H7. If <i>Salmonella</i> , <i>Shigella</i> , or <i>E. coli</i> O157:H7 follow health department recommendations for exclusion. Emphasize thorough hand washing by children and personnel after using the toilet and diapering, and before eating and preparing food.	When 2 or more children in the same classroom have diarrhea, either known or presumed to be of the same etiology, notify the local health department. Single cases of <i>Salmonella</i> , <i>Shigella</i> , <i>E. coli</i> O157:H7 infections, and all outbreaks are reportable.*
DIPHTHERIA*	2 to 5 days, occasionally longer.	Patches of grayish membrane with surrounding redness of throat, tonsils, larynx, nose, other mucous membranes, or skin. Mild cases are often confused with simple tonsillitis.	Person-to-person contact with respiratory secretions or skin lesions of cases or carriers.	Up to 2 weeks if untreated.	Exclude until case has 2 negative cultures for <i>Corynebacterium diphtheriae</i> . Culture close contacts; give antibiotics and vaccine. Exclude culture positive contacts from food handling or child care/school until cultures are negative.	Prevent with immunization. Immunize with DTaP or DTP: 4 doses (primary series) by 16 months of age with a booster at 4 to 6 years; Td vaccine for children age 7 years and above, and every 10 years for adults. Diphtheria vaccine is required for child care and school attendance.
FIFTH DISEASE (Erythema Infectiosum)	4 to 20 days.	Red, patchy facial rash (giving a "slapped cheek" appearance) that may spread to the rest of the body in a lace-like pattern. Rash may be preceded by cold-like symptoms. In adults, joint pains or arthritis are likely. About 25% of cases are asymptomatic.	Contact with respiratory secretions of an infected person; by contaminated blood or blood products; from an infected mother to fetus.	Before onset of rash in most cases; probably not communicable after onset of rash.	Exclusion of case is not recommended. Those likely to develop complications (persons with chronic hemolytic anemias or immunodeficiencies, and non-immune pregnant women) should be informed but not routinely excluded from settings where fifth disease is occurring. Persons with aplastic crises should be excluded until cleared by a physician.	Approximately half of adults in the U.S. have had fifth disease and are immune for life. Pregnant women and persons likely to develop complications should consult with a physician if exposed. Handwashing is important.

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GONORRHEA*	2 to 7 days, occasionally longer.	Men: purulent discharge from penis, painful urination; may have atypical discharge or no symptoms. Women: usually no symptoms; may have vaginal discharge, urinary frequency, or lower abdominal pain.	Person-to-person by sexual contact. Newborn infants may acquire gonococcal conjunctivitis at birth while passing through the birth canal.	May extend for months if untreated, especially in asymptomatic men and women.	Routine exclusion of case is not recommended. Cases should be treated with antibiotics. Sexual contacts should be tested and given preventive treatment with antibiotics.	Pelvic inflammatory disease (PID) may occur in untreated females, and can lead to sterility, ectopic pregnancy, or chronic pain. Arthritis, meningitis, or heart involvement may occur, if untreated. Persons treated for gonorrhea should also be treated for chlamydia infection.
<i>Haemophilus influenzae</i> type b (Hib) DISEASE*	Unknown; may be 2 to 4 days.	This bacteria can cause a variety of symptoms depending on the site of infection such as ear, eye, skin, joint, and blood infections, pneumonia, and meningitis.	Contact with discharges or droplets from the nose or throat of an infected person; by direct person to person contact.	Until 24 hours after effective antibiotic treatment. If untreated, during the course of active infection.	Exclude case until 24 hours after start of antibiotic treatment. Household and child care contacts may need an antibiotic to prevent Hib disease but do not need to be excluded. Contact local health department regarding need for prophylaxis.	Hib vaccine series is recommended for children from 2 months of age until age 5. Hib vaccine is required for child care and pre-school; not required for school (grades K-12).
HEPATITIS A*	15 to 50 days, usually 28 to 30 days.	Jaundice, dark urine, loss of appetite, nausea, fatigue, abdominal discomfort, and fever. No symptoms or mild symptoms without jaundice may occur in most children less than 2 years old and some adult cases.	Person-to-person by fecal-oral spread; by ingestion of contaminated food or water.	2 weeks before to 1 week after onset of jaundice.	Exclude case until 1 week after onset. Immune globulin (IG) given to close contacts within 2 weeks of exposure may protect for 5 to 8 months. Hand washing after using the toilet and diapering, and before eating and preparing food, is necessary to prevent and control outbreaks.	In child care settings, the infection may spread asymptotically among children and only become evident when parents and teachers become cases. Hepatitis A vaccine will protect against getting disease.
HEPATITIS B*	6 weeks to 6 months, usually 2 to 3 months.	Insidious onset with dark urine, fatigue, loss of appetite, nausea, vomiting, sometimes joint pain, and often followed by jaundice. Some cases are mild. The infection may be asymptomatic, especially in children.	Person-to-person through sexual contact; exposure to infected blood; from mother to infant during pregnancy or birth.	Several weeks before and several weeks after the onset of symptoms; some persons remain chronic carriers of HBsAg for many years.	Routine exclusion is not recommended. Practice standard infection control precautions. Non-immune persons exposed to HBsAg positive blood should be given hepatitis B immune globulin (HBIG) and vaccine.	Hepatitis B vaccine (3 doses) is indicated for all babies and for anyone who may have blood exposure or who has routine contact with a case or carrier, including household and sexual contacts of carrier. Hepatitis B vaccine is required for child care and will be required for entry into Pre-K in September 2000.

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HERPES SIMPLEX VIRUS (Cold Sores, Fever Blisters)	2 to 12 days	Oral herpes: sores or blisters on the lips or mouth. Genital herpes: sores or blisters in the genital area.	Direct contact with saliva, sores, or blisters such as through touching, kissing, or having sex; from mother to infant during delivery, less common during pregnancy and postpartum.	As long as the sores or blisters are present, about 1 to 2 weeks. Viral shedding may occur in the absence of symptoms.	Routine exclusion is not recommended. Exclude from child care only those children with first time herpes of the mouth, i.e., primary gingivostomatitis, who do not have control of their secretions (drooling). Avoid kissing, contact with saliva, or other direct contact with sores or blisters. Use gloves if touching lesions. Wash hands well.	Pregnant women with herpes should consult with their doctor. Cover lesions if possible.
HIV (Human Immunodeficiency Virus) Infection (includes AIDS*)	Variable. The commonly used HIV antibody tests will detect infection in most people within 6 to 12 weeks after infection; however, it may take up to 1 year for the test to detect HIV antibody.	HIV infection may be asymptomatic for many years. Symptoms in later stages are variable, depending on opportunistic infections.	Person-to-person through sexual contact; exposure to HIV-infected blood, e.g., dirty needles; from mother to infant during pregnancy or birth.	Throughout the life of an infected individual.	Routine exclusion is not recommended. Educate on how to prevent HIV transmission; use standard infection control precautions to avoid exposure to blood or any body fluid except sweat.	Supplies needed to implement standard infection control precautions, including gloves and appropriate disinfectant cleaners, must be available.
IMPETIGO	4 to 10 days.	Blister-like lesions which later develop into crusted sores which are irregular in outline. Usually caused by <i>Staphylococcus aureus</i> and <i>Streptococcus pyogenes</i> .	Direct contact with draining sores. Less commonly by touching articles contaminated with the blister fluid.	From onset of symptoms until sores are healed.	Exclude until 24 hours after start of antibiotic treatment. Topical treatment and/or antibiotics needed; cover lesions. Hand washing by caretakers reduces transmission. Infected individuals should use separate towels and washcloths.	All persons with lesions should avoid contact with newborn babies.

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LYME DISEASE*	3 to 32 days.	A distinctive skin lesion appears as a red spot or bump which expands to greater than 2 inches, with malaise, fatigue, fever, headache, stiff neck, joint pain for several weeks. Neurologic, cardiac, or arthritic complications may follow.	By bite of an infected deer tick that has been left attached for 24 hours or more.	(No documented person-to-person or vertebrate animal-to-person spread.)	Routine exclusion is not recommended. Avoid exposure to deer ticks; when outdoors, wear protective clothing, use repellants, inspect entire body every 3-4 hours, and promptly remove attached ticks. If tick bite occurs, record date and body site and save tick. Consult physician if skin rash or early symptoms occur.	Treatment with antibiotics to prevent complications should start upon suspected diagnosis (based on history of tick exposure and clinical signs and symptoms). Prophylactic administration of antibiotic is not usually recommended.
MEASLES* (Rubeola)	7 to 18 days, usually 10 days from exposure to onset of fever, and usually 14 days from exposure to onset of rash.	Sudden onset of chills, followed by sneezing, running nose, conjunctivitis, photophobia, fever, and cough. The rash, seen about 2 to 7 days later, usually appears first behind the ears or on the forehead and face; it is blotchy and usually dusky red and spreads rapidly over the face, trunk, and limbs. Small white spots (Koplik spots) may appear inside the mouth.	Droplet spread or direct contact with throat or nasal secretions of an infected person.	4 days before to 4 days after the rash appears.	Exclude case for at least 4 days after onset of rash. Susceptible contacts may be protected if vaccine is given within 72 hours of exposure, or immune globulin within 6 days of exposure. After exposure, exclude susceptibles from school or child care until approved to return by health department. Pregnant women should check with their doctor if exposed.	Very communicable. Immunize all children routinely at 12 months of age with MMR (measles-mumps-rubella) vaccine. Measles vaccine is required for child care and preschool; second dose of measles vaccine is required for all children in grades K-12 and for pre-schoolers exposed to measles cases.

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MENINGO-COCCAL DISEASE*	2 to 10 days, usually 3 to 4 days.	Sudden onset with fever, vomiting, intense headache, and stiffness of the neck. Small bright red spots may appear on the body.	Close contact with droplets and discharge from nose or throat of an infected person.	Not longer than 24 hours after the start of effective chemotherapy. Asymptomatic carriers are common.	Case needs antibiotics. Exclude case for 24 hours after start of antibiotic treatment. A prophylactic antibiotic is recommended for household, child care contacts, and others with saliva contact, e.g., kissing, CPR. Contacts should watch for symptoms for 2 weeks and should seek immediate medical attention if ill.	Vaccine is now available for certain types of meningococcal disease and can be used in outbreaks.
MUMPS* (Infectious Parotitis)	12 to 25 days, usually 16 to 18 days.	Fever, swelling, and tenderness of the salivary gland; may be asymptomatic. The parotid glands in front of and below the ears are most frequently affected. Meningitis may occur. In post pubertal males, involvement of the testes may occur.	Droplet spread and direct contact with nose or throat discharge of an infected person.	From 6 days before salivary gland enlargement to 9 days after.	Exclude case for 9 days after onset of swelling. A live attenuated virus vaccine is available alone or combined with measles and rubella vaccines (MMR). Pregnant women should check with their doctor if exposed. Follow health department recommendations for exclusion of susceptible contacts.	Very communicable. Immunize all children routinely at 12 months with MMR vaccine. Mumps vaccine is required for child care and school attendance.
PEDICULOSIS (Head Lice)	Eggs (nits) of lice hatch into nymphs in a week; nymphs become sexually mature, mate, and lay eggs in 8 to 10 days after hatching.	Asymptomatic, or itching of the scalp. Nits are tightly attached to the shaft of the hair close to the scalp; crawling lice can be seen most commonly at the nape of the neck and behind the ears.	Direct contact with infested persons, or contact with their clothing, combs, brushes, carpets, or linens. Lice generally die when away from a host for more than 48 hours.	Communicable while lice remain alive on infested person or on clothing, and until eggs (nits) have been destroyed.	Treat case with medicated shampoo or medicated creme rinse (pediculicide). Launder (using hot cycles of washer and dryer) or dry clean clothes and bedding. Case may return to child care or school the morning after treatment. Removal of nits may be recommended for return to school. Retreatment in 7 days may be necessary. Contacts should be examined and treated if they are infested.	Common in school-age children. The head louse does not transmit any communicable disease. It is important that the manufacturer's recommendations regarding treatment be followed, and that nits be removed.

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PERTUSSIS* (Whooping Cough)	6 to 20 days, usually 7 to 10 days.	Acute onset of cough which becomes repeated and violent within 1 to 2 weeks and lasts for 1 to 2 months or more. Thick mucus and vomiting after a coughing spell is characteristic. Young infants and adults may not have the typical inspiratory "whoop."	Direct contact with respiratory discharges of an infected person by airborne droplets.	Most infectious before the typical cough begins and until approximately 3 weeks after the onset of cough in untreated cases. Antibiotics shorten communicability but may not reduce symptoms.	Treat case with antibiotics for at least 14 days. Exclude case for first 5 days of appropriate antibiotic treatment. Contacts should be evaluated for receiving antibiotics and vaccine, and for exclusion recommendations.	Highly communicable. Prevent through immunization with DTaP or DTP vaccine: 4 doses by 16 months of age with a booster dose at 4 to 6 years. Pertussis vaccine is required for child care and school attendance until age 7; pertussis vaccine is not indicated for children age 7 years and above.
POLIO-MYELITIS*	3 to 35 days, usually 7 to 14 days.	Symptom severity ranges from inapparent infection, to mild illness (fever, malaise, headache, vomiting), to severe illness (meningitis, muscle paralysis, death).	Contact with nasal or pharyngeal discharges; by fecal-oral spread.	Not accurately known. Cases are probably most infectious during the first few days before and after onset. Virus remains in throat about 1 week, and in feces for 3 to 6 weeks or longer.	Exclude case until health officer approves readmission. Susceptible contacts should receive polio vaccine.	No wild type polioviruses have been found in the U.S. since 1979. Every child should receive the primary polio vaccine series: 3 doses by 16 months of age, with a booster dose at 4 to 6 years. Polio vaccine is required for child care and school attendance.
RABIES*	Human: Usually 3 to 8 weeks, rarely as short as 9 days or as long as 7 years. Animal: 3 to 11 weeks after exposure (can be shorter or longer depending on location of bite, type and amount of virus).	Human: Apprehension, headache, fever, malaise, paresis or paralysis, hydrophobia (fear of water), delirium, convulsions, and death due to respiratory paralysis. Animal: Behavior change (aggression or stupor), increase in salivation due to an inability to swallow, and paralysis of limbs. Death due to respiratory paralysis usually occurs within 2 to 7 days after onset.	Contact with saliva of an infected animal (dog, raccoon, etc.) through a break in the skin (scratch, bite) or a mucous membrane. Person-to-person spread never documented except through corneal transplant. While rare, airborne spread has been demonstrated in a cave where many bats were roosting and in laboratory settings.	Domestic animals: For dogs and cats, usually 3 to 7 days before onset of clinical signs (rarely over 4 days) and throughout course of disease. Wild and exotic animals: Unknown.	Human Exposure: Wash wound thoroughly with soap and water. Give postexposure prophylaxis (PEP) promptly when indicated. Domestic Animal: Confine cat, dog, or farm animal that has exposed a human and observe for 10 days. If signs of rabies appear, veterinary examination and laboratory testing are necessary. Wild and Exotic Animal: Test animal immediately for rabies if recommended by the local health department.	Animal bites, scratches, mucous membrane exposures, and situations where lack of exposure can not be documented, e.g., bat was in the room with a sleeping child, should be immediately reported to police or local health department by telephone. PEP should begin as soon as possible when exposure occurs. If not previously vaccinated, give human rabies immune globulin (HRIG) and five doses of human diploid cell rabies vaccine (HDCV) on days 0, 3, 7, 14, and 28. When a domestic animal is bitten by a wild animal e.g., raccoon, consult the local health department.

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RINGWORM OF SCALP (Tinea Capitis)	10 to 14 days.	Patchy areas of dandruff-like scaling and hair loss; many separate blisters with pus in them with little hair loss; or a soft, red swollen area of scalp.	Direct person-to-person contact or indirect contact with contaminated surfaces or objects such as combs, brushes, furniture, fabric, clothing, and hats from infected persons or animals.	Until rash/lesions heal.	Infection of the scalp requires oral antifungal therapy, generally for 4 to 6 weeks as directed by a physician. Children receiving treatment may return to child care or school. Examine household, child care, school, and animal contacts; treat if infected.	Infected children should not share combs, brushes or hair ornaments while being treated. Haircuts or shaving of the head is not necessary. Selenium shampoo used twice a week decreases shedding of fungus.
RINGWORM OF SKIN/BODY (Tinea Corporis)	4 to 10 days.	Infection involves the face, trunk, or extremities. Rash is usually circular, slightly red with a scaly border and may be itchy.	Direct person-to-person or animal contact or indirect contact with contaminated articles such as floors, showers, and benches.	Until rash/lesions heal.	Routine exclusion is not recommended. Most cases are treated with topical antifungal medication for about 4 weeks. While being treated, exclude from gymnasiums, swimming pools, and activities likely to lead to exposure of others. Examine household, child care, school, and animal contacts; treat if infected.	Avoid direct contact with known infected persons and animals.
RUBELLA* (German Measles)	14 to 23 days, usually 16 to 18 days.	Mild illness with low fever, mild rash, usually associated with enlargement of nodes on the back of the neck. A rash is often the first symptom and may resemble measles, scarlet fever, or erythema infectiosum (fifth disease). Fetal infection may lead to spontaneous abortion, congenital malformations, or defects of organs.	Contact with droplets or direct contact with nose and throat discharges of an infected person, and possibly blood or urine; from mother to infant during pregnancy.	For about 7 days before and at least 4 days after onset of rash. Infants with congenital rubella may shed virus for months after birth.	Exclude for 7 days after onset of rash. Pregnant women should check with their doctor if exposed. Follow health department recommendations for exclusion of contacts who have not had rubella vaccine.	Highly communicable. Immunize all children routinely at 12 months with MMR vaccine. Exposed pregnant women should be evaluated for their susceptibility to rubella. Infection during pregnancy, especially in the first trimester, results in congenital rubella syndrome in $\geq 24\%$ of cases. Rubella vaccine is required for child care and school attendance.

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SCABIES	2 to 6 weeks; 1 to 4 days in reinfestations.	Rapid onset of red papular rash involving the fingers, wrists, elbows, knees, and other skin surfaces. Intense itching, especially at night. A classic burrow or a demonstrated mite or ovum are diagnostic.	Direct skin-to-skin contact, such as holding hands or sexual contact or through contaminated clothes.	Until mites and eggs are destroyed, usually after 1 to 2 courses of treatment.	Treat case with scabicide. Exclude infested persons from school or child care until 24 hours after start of treatment. Household and close contacts should be treated at the same time as the patient. Clothing, bedding, and other personal articles should be laundered using hot cycles of washer and dryer or dry cleaned.	Itching may persist after treatment due to allergic reaction. Secondary bacterial infections of the skin may result from scratching. Mites do not transmit any communicable disease. Mites generally die when away from a host for more than 48 hours.
STREPTOCOCCAL SORE THROAT, SCARLET FEVER (Scarlatina)	1 to 3 days, occasionally longer.	Sudden onset of headache, fever, and sore throat. Lymph nodes of neck tender and enlarged. In scarlet fever, streptococcal sore throat is accompanied by a fine red "sand paper" rash most often on neck and chest, lasting 1 to 10 days. When it fades, the skin peels, especially on toes and fingers.	Person-to-person contact with discharge from nose and throat of a case or carrier. Mild cases and carriers are important in the spread of the disease. May be foodborne through food or milk.	Until 24 hours after appropriate antibiotic treatment is begun; 10 to 21 days in untreated cases.	Exclude case until 24 hours after start of antibiotic treatment. Exclude infected food handlers from work until 24 hours after start of treatment.	Asymptomatic carriage is common in school children. Outbreaks are uncommon. Early recognition and adequate treatment are important to prevent complications, such as rheumatic fever or kidney disease.
SYPHILIS*	10 days to 3 months, usually 3 weeks.	Painless ulcer on the genitals, anus, or mouth which may go unnoticed; rash on palms and soles, body rash, raised, moist patches, and generalized lymph node swelling; may have no symptoms.	Sexual contact with an infected person; from mother to infant during pregnancy or at delivery.	Whenever infectious lesions, e.g., ulcers, moist patches, rash, are present (in primary and secondary stages). Adequate treatment ends infectivity within 24 to 48 hours.	Case should be treated with antibiotics. Routine exclusion is not recommended. Sexual contacts should be examined and given preventive treatment with antibiotics. All infants born to women with a positive blood test should be evaluated for evidence of congenital syphilis and treated if indicated.	Long-term, untreated syphilis can lead to severe damage of cardiovascular, nervous, and other organ systems. Only severe cases of congenital syphilis are clinically apparent at birth. Although symptoms may resolve without treatment, the organism remains present and may cause long term effects.

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TYPHOID FEVER*	3 to 60 days; usually 1 to 3 weeks.	Fever, headache, red (rose) spots on the body, slow heart rate, and constipation more often than diarrhea.	Direct person to person contact: by ingestion of contaminated food or water.	For as long as a person carries the organism in feces or urine.	Exclude case until 3 stool cultures for <i>Salmonella typhi</i> collected 24 hours apart (and 48 hours after discontinuation of antibiotics, if given) are negative. Emphasize thorough hand washing by children and personnel after toilet use and diaper changes, and before preparing food and eating.	Typhoid fever vaccine is recommended for travelers to countries where there is a risk of exposure.
TUBERCULOSIS (TB)*	2 to 10 weeks from infection to positive PPD skin test; risk of active TB greatest during the first 2 years after infection, but can occur throughout life.	Insidious onset extending over several weeks, characterized by chronic cough, hoarseness, fatigue, loss of weight, fever, bloody sputum.	Person-to-person exposure to TB bacteria in respiratory airborne droplets from a person with active TB of the lungs.	Most patients will no longer be contagious after 2 to 3 weeks of appropriate antibiotics. Untreated or inadequately treated patients may be infectious for years.	Report case to local health department. Exclude TB case from school and work until local health officer certifies case to be non-infectious. Contacts should be investigated according to local health department policy. A child with TB will lead to an investigation into the source of infection such as parents and child care contacts.	Active TB requires treatment with multiple antibiotics over 4 to 6 months. Teach children to cover mouth when coughing. Children with TB are poor transmitters of TB bacteria. If positive skin test, x-ray needed to rule out active TB and evaluation needed for TB preventive therapy. 10 to 25% of patients with pulmonary TB may have a negative PPD skin test.

* Diseases marked with an asterisk (*) are reportable by school and child care personnel to their local health department. Outbreaks of any disease are also reportable.

† Periods of exclusion are intended for cases in schools and child care settings. Different periods of exclusion may apply in different settings (e.g., health care, food handling). Also, periods of exclusion are minimum periods; physicians may recommend longer periods of exclusion based on severity of illness.

Contact your local health department for recommendations on diseases or conditions not addressed above.