Maryland
DEPARTMENT OF HEALTH

Maryland Communicable Diseases Summary

A Guide for School Health Services Personnel, Child Care Providers and Youth Camps

Revised August 2024

Table of Contents

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Use of This Document

The intent of this document is to provide general guidance to school health services personnel, child care providers, and youth camp owners/operators about common communicable diseases. It is not intended for use as a diagnostic guide. Please consult a health care provider (HCP) for any situations which require medical attention. This guidance is to be used in conjunction with School Health Services (SHS), local health department (LHD), and other Maryland Department of Health (MDH) guidance, and applies to individual or sporadic cases of the communicable diseases described below. Outbreaks or unusual situations may require additional control measures implemented in consultation with the LHD. The procedures in this document represent measures specific to school, child care, or youth camp settings. References to SHS Guidelines are intended for use by schools in programs serving school-aged children.

If a child's HCP provides exclusion recommendations which conflict with these guidelines, please consult with your LHD. If parents have additional questions, they should contact their HCP or LHD.

This document is intended to guide the development of specific local policy and procedures regarding management of communicable diseases in schools, child care, and youth camps. These policies and procedures should be implemented in collaboration and in consultation with LHDs, school health services programs, local child care authorities, and youth camp regulatory authorities.

Definitions

Diarrhea: Loose or watery stools of increased frequency above the normal for that child that are not associated with change in diet

Fever: For the purposes of this guidance, fever is defined as an oral or mouth temperature of 100° F (37.8° C) or higher, a rectal, ear or forehead temperature of 100.4° F (38.0° C) or higher, or under the arm (armpit) temperature of: 99° F (37.2° C) or higher.

Infection control measures: Common infection control measures include but are not limited to:

- Handwashing - Careful handwashing with soap and water is an important step in preventing the spread of many types of infections. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol. For children under six years of age, hand sanitizer should be used with adult supervision; when used, follow the manufacturer's label instruction. Note that if norovirus is suspected, soap and water should always be used, as hand sanitizer is not effective against norovirus.
- Ue of personal protective equipment, such as gloves (latex-free recommended), masks, eye protection, face shields, gowns
- Exclusion of an individual or isolation in a separate area of the facility, including exclusion of individuals showing symptoms of illness or exacerbation of symptoms for a controlled/chronically managed health conditions to be temporarily excluded for further testing and treatment
- Adequate ventilation
- Age-appropriate and seasonal vaccinations.
- Thorough environmental cleaning and disinfection, including proper handling of soiled equipment and linen; proper disposal of sharp equipment (e.g., needles), and careful attention to proper procedures for cleaning, sanitizing, and disinfecting, particularly for high-touch surfaces, and after activities such as diapering, feeding, and contact with bodily fluids (How to Clean and Disinfect Early Care and Education Settings).

Influenza-like illness: A respiratory illness with a temperature of 100°F (37.8°C) or greater orally PLUS cough or sore throat.

Outbreak: In general, an outbreak is defined as an increase in the number of infections that occur in a facility above the expected or baseline rate. Outbreaks of any kind must be reported to the LHD for the county in which the facility is located. This document is intended to provide general information on a variety of conditions and situations. In some cases, in response to an outbreak, the health department may require longer exclusions and/or additional control measures beyond what is stated in this guide. For more disease-specific information related to outbreaks, including outbreak definitions and control measures, please visit https://health.maryland.gov/phpa/pages/guidelines.aspx. If you have questions about whether a particular situation should be considered an outbreak, please contact your LHD.

Reportable disease/condition: Maryland statute, Maryland Code Annotated, Health-General ("Health-General") §18-201 and §18-202, and Maryland regulation, Code of Maryland Regulations ("COMAR") 10.06.01.04 "Communicable Diseases" and 10.16.06.25 "Certification for Youth Camps", require that

HCPs, school and child care personnel, masters of vessels or aircraft, medical laboratory personnel, owners/operators of food establishments, and owners/operators of youth camps, submit a report in writing or notification by telephone of diagnosed or suspected cases of specified diseases to the Commissioner of Health in Baltimore City or the health officer in the county where the provider cares for that person. A list of reportable diseases and conditions can be found at https://health.maryland.gov/phpa/pages/what-to-report.aspx.

Vomiting: Two or more episodes of vomiting in a 24-hour period

General Considerations

Exclusion: In general, children should be excluded when they are not able to fully participate with the program, or when their level of care needed during an illness is not able to be met without jeopardizing the health or safety of others, or when there is a risk of spread to others that cannot be avoided with appropriate environmental or individual management. For exclusion, all applicable COMAR regulations should be followed; for youth camps, specifically COMAR 10.16.07.12 "Exclusion for Acute Illness and Communicable Disease". Note that periods of exclusion listed in this document are intended for individual cases in school, child care, and youth camp settings. During an outbreak, the health department might recommend exclusions beyond what is required for individual case management, in order to control the outbreak.

Fever: A child may have a fever for many reasons. If a child has a fever, all applicable COMAR regulations should be followed. In addition, any child with a fever and behavior changes or other symptoms or signs of an acute illness should be excluded and parents notified. Once diagnosed, exclusion due to fever should be based on disease-specific guidelines or other clinical guidance from the child's health care provider (HCP). Typically, a child should not return to school, child care, or camp until the child has not had a fever, and is not using fever-reducing medicines, for at least 24 hours (in addition to any other disease-specific or clinical guidelines regarding return to normal activities). Also, it is important to be sure the appropriate method for measuring temperature is used based on the age or developmental level of the child.

An unexplained fever in any child younger than 3 months requires medical evaluation.

Fever in a child the day following an immunization known to cause fever may be admitted, along with HCP recommendations for fever management and indications for contacting the HCP. Instructions from the HCP should include: the immunizations given, instructions for administering any fever reducing medication, and medication authorizations signed by the parent and the HCP.

Diarrhea: Diarrhea might result in stools that are not able to be contained by a diaper or be controlled/contained by usual toileting practices. An infectious cause of diarrhea might not be known by the school, child care facility, or camp at the time of exclusion or return. Documentation of the cause of diarrhea should be sought.

A child with diarrhea should be excluded if any of the following occur:

- Stool is not able to be contained in a diaper or in the toilet, or child is soiling undergarments
- Stool contains blood
- Child is febrile or has any other signs of acute illness
- Child shows evidence of dehydration (such as reduced urine output or dry mouth)

With appropriate documentation, a child with diarrhea may be readmitted to care, school, or camp when:

- An infectious cause of diarrhea (see chart) has been treated and the child is cleared by a HCP, in conjunction with the LHD, if necessary
- The diarrhea has been determined by the LHD to not be an infectious risk to others

Vomiting: An infectious cause of vomiting might not be known by the school, child care facility, or camp at the time of exclusion or return. Documentation of the cause of vomiting should be sought. The child should be excluded until vomiting resolves (or until a HCP clears the child for return or it has otherwise been determined that the child does not pose an infectious risk to others) and until the child can tolerate enough oral intake to stay hydrated .

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
BED BUGS **(Cimex lectularius)**	Bite marks appear anywhere from one to several days after the initial bite.	Itchy, skin welts occur a day after the bite. The medical concern is usually limited to itching and inflammation of the welts. Infestations may cause anxiety and loss of sleep. If badly affected, seek medical care promptly.	Bed bugs are usually carried into a home or facility unknowingly. People carry them on luggage, clothing, beds, and furniture, especially used beds and sofas. Once inside, they spread from room to room and live for months without food or water.	N/A	No, if bed bugs are found on a child, the child should not be sent home early or excluded immediately.	Clothing may be placed in disposable plastic bags and then taken directly into the washer and/or dryer. For infestations of facilities, it is recommended to enlist the services of a professional pest control firm. The best way to prevent bed bugs is regular inspection for the signs of an infestation. See Bed Bugs Go to School: A Guide for Teachers and Staff.	Bed bugs are not known to spread disease.		
BITES, ANIMAL	N/A	Varies, can include redness, pain, swelling, drainage around area bitten. May develop fever, lymph node enlargement.	Direct contact	N/A	No, exclusion is not routinely recommended as long as student/child does not meet any other exclusion criteria.	Medical follow-up is strongly recommended. For school age children, see the SHS Guidelines for Emergency Care in Maryland Schools". For preschool age children, contact the child's HCP.	After immediate needs of bite victim(s) are taken care of, notify LHD and appropriate local authority (police, sheriff, animal control) immediately. [Also, see section for "Rabies".]	X	

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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BITES, HUMAN	N/A	Varies, may include redness, pain, swelling, drainage around area bitten. May develop fever, lymph node enlargement.	Direct contact	Variable, depending on cause; average 24 hrs before to 5 days after symptoms have started.	No, exclusion is not routinely recommended as long as student/child does not meet any other exclusion criteria.	Medical follow-up strongly recommended. For school age children, see the SHS Guidelines for Emergency Care in Maryland Schools". For preschool age children, contact the child's HCP. Assess immunization status of children involved, including tetanus and Hepatitis B vaccination.	After immediate needs of bite victim(s) are addressed, notify responsible authority and parent/guardian. Also, see the SHS Guideline Bloodborne Pathogens Control And Handling Body Fluids in the School Setting.		

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CHLAMYDIA **(Chlamydia trachomatis)**	Usually 7-14 days; up to 30 days	May be asymptomatic; genital infection can include purulent discharge, painful urination, and lower abdominal pain. Symptoms of conjunctival infection include painful,swollen eyelids.	Sexual contact: genital, oral, anal. Conjunctivitis: from infected mother to infant.	Variable	No, exclusion is not routinely recommended.	Doxy PEP has proven to reduce the risk of getting a bacterial STI for gay, bisexual, and other men who have sex with men and transgender women at increased risk for these infections (specifically, syphilis, chlamydia, gonorrhea). https://www.cdc.gov/sti/php/from-the-director/doxy-pep-sti-prevention-strategy.html Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. https://www.cdc.gov/std/ept/default.htm	All cases should be referred to a HCP for assessment (including potential for gonorrheal co-infection) and possible treatment. This infection in a child may possibly be an indicator of sexual abuse. Camp operators, health practitioners, police officers, educators, and human service workers are required to report child abuse (COMAR 10.16.06.35, § 5-704).	X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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CMV **(Cytomegalo-virus, Human herpesvirus 5)**	Usually 3-12 weeks	Non-specific febrile illness; asymptomatic infections common. Adolescents and adults might have fever, sore throat, fatigue, swollen glands, and mild hepatitis. Immunocompromised individuals might develop pneumonia, colitis, or retinitis.	Through mucosal contact with infected secretions or excretions (such as urine, saliva, feces, blood and blood products, breast milk, semen, cervical secretions)	Variable; may be many months or episodic for several years	No, exclusion is not routinely recommended.	Emphasize washing hands often, especially after toileting and diapering. Thorough environmental cleaning with a cleaner effective against this pathogen.	A pregnant woman or a woman who is considering pregnancy should talk to her doctor if she cares for infants or young children, or handles urine or saliva in any home or occupational setting. Pregnant women do not necessarily need to be excluded from such situations.		
CONJUNCT-IVITIS, INFECTIOUS **(Pink Eye)**	Usually 1-3 days, though can vary with agent	White or yellow discharge, accompanied by pink or red conjunctiva, redness and swelling of the lids, and matted, sticky lids. Low-grade fever, headache, malaise can occur, particularly in the presence of other upper respiratory infection symptoms.	Contact with discharge from conjunctiva or upper respiratory tracts of infected people; also by contact with contaminated hands or other articles; contaminated swimming pools are rarely a source of infectious pink eye.	Variable, depending on cause, from several days to weeks.	Yes, until cleared for return with documentation from a HCP, or after taking antibiotics for 24 hours, or until symptoms have resolved. NOTE: Exclusion not necessary for allergic conjunctivitis if evaluated and documented by a HCP.	Emphasize hand hygiene and respiratory etiquette. Conduct thorough environmental cleaning, including cleaning/disinfection of soiled articles and potentially contaminated surfaces.	Refer any newborn with conjunctivitis to a HCP. Infectious conjunctivitis can be caused by either bacterial or viral agents.		

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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COVID-19 (SARS-CoV-2)	Usually 2-14 days	Wide range of possible symptoms from mild to severe illness, including fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea.	Primarily spread from person-to-person via respiratory droplets and aerosols.	Anyone infected with COVID-19 can spread it, even if they do not have symptoms. An individual that tests positive for COVID-19 is likely most infectious in the first 5 days.	See guidance here: https://www.cdc.gov/respiratory-viruses/prevention/precautions-when-sick.html	Emphasize vaccination, hand hygiene and respiratory etiquette and adequate ventilation. Conduct thorough environmental cleaning, including cleaning/disinfection of soiled articles and potentially contaminated surfaces. Vaccination. Antiviral treatment is recommended for eligible patients to reduce the severity, and duration of symptoms and communicability of the virus. See https://www.cdc.gov/respiratory-viruses/guidance/index.html for additional information.		X	X
DIARRHEAL ILLNESS: CAMPYLO-BACTER	Usually 2-5 days; range 1-10 days.	Diarrhea with or without blood, abdominal pain, fever, cramps, malaise, nausea and/or vomiting. Fever and malaise may precede diarrhea by a day or more.	Spread from person-to-person by fecal contact, contact with infected pets, or from ingesting contaminated foods such as raw or undercooked meats, unpasteurized milk, or untreated water.	Usually 2-3 week in untreated cases,but may be up to 7 weeks.	Yes, exclude until diarrhea has resolved and child is diarrhea-free for at least 24 hours; or until cleared by the LHD.	Emphasize washing hands often, especially after toileting and diapering. Thorough environmental cleaning with a cleaner effective against this pathogen.		X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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DIARRHEAL ILLNESS: **E. COLI O157:H7 and other STEC (Shiga Toxin-producing E. coli)**	Usually 3-4 days; range 1-10 days	Severe abdominal pain, diarrhea with or without blood, and vomiting	Spread from person-to-person by fecal-oral route or ingesting under-cooked beef, unpasteurized milk or juices, raw fruits or vegetables, or contaminated water.	Usually 1-3 weeks.	Yes In child care, exclude until cleared by the LHD. Contact the LHD for guidance. In other settings, exclude until diarrhea has resolved and child is diarrhea-free for at least 24 hours; or until cleared by the LHD.	Emphasize washing hands often, especially after toileting and diapering. Thorough environmental cleaning with a cleaner effective against this pathogen.		X	X
DIARRHEAL ILLNESS: GIARDIA	Usually 7-10 days; range 3-25 days.	Acute watery diarrhea with abdominal pain, bloating, frequent loose and pale greasy stools, fatigue and weight loss. Might lead to chronic diarrhea that persists from weeks to months.	Person-to-person by fecal-oral route through direct contact with infected person or ingestion of contaminated food or recreational/drinking water.	Entire period of infection, often months.	Yes, until diarrhea has resolved.	Emphasize washing hands often, especially after toileting and diapering. Thorough environmental cleaning with a cleaner effective against this pathogen.		X	X

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DIARRHEAL ILLNESS: NOROVIRUS	Usually 10-50 hours.	Nausea, vomiting, abdominal cramps, diarrhea, myalgia, malaise, low grade fever, headache.	Person-to-person by fecal contact or from ingesting contaminated foods. Commonly transmitted by contaminated surfaces, objects. Possible transmission via aerosolized particles.	24-72 hours after symptoms resolve, sometimes longer	Yes, exclude for 48 hours after last episode of diarrhea or vomiting.	Emphasize washing hands with soap and water often, especially after toileting and diapering, and thorough environmental cleaning using bleach or another cleaner effective against this pathogen.			X
DIARRHEAL ILLNESS: ROTAVIRUS	Usually 1-3 days	Watery diarrhea, frequently with vomiting and fever.	Fecal-oral route, through close person-to-person contact and by fomites (i.e., toys, other contaminated environmental surfaces)	Highly communi-cable. 2 days before onset of diarrhea and for several days after symptoms resolve, sometimes longer in persons with weakened immune systems.	Yes, exclude until 24 hours after resolution of symptoms.	Vaccination; emphasize washing hands often, especially after toileting and diapering; thorough environmental cleaning with a cleaner effective against this pathogen.			**X**

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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DIARRHEAL ILLNESS: SALMONELLA	Usually 12-36 hours; range 6-72 hours	Diarrhea with or without blood, fever,abdominal cramps,nausea, vomiting, headache	Direct or indirect contact with infected animals or their environment; ingestion of contaminated water or foods (e.g.poultry, beef, fish, eggs, dairy, raw produce; contact with infected reptiles. Person-to-person transmission by fecal-oral route also possible.	Throughout the course of infection; extremely variable, usually several days to several weeks.	Yes, exclude until diarrhea has resolved and child is diarrhea-free for at least 24 hours; or until cleared by the LHD.	Emphasize washing hands often, especially after toileting and after diapering; thorough environmental cleaning using bleach or another cleaner effective against this pathogen.		X	X
DIARRHEAL ILLNESS: SHIGELLA	Usually 1-3 days; range 1-7 days	Abdominal cramps,fever, diarrhea with blood and mucous; also watery diarrhea. Sometimes nausea or vomiting.	Direct or indirect fecal-oral transmission from a symptomatic patient or asymptomatic carrier; ingestion of contaminated water or food.	During acute infection and up to 4 weeks after illness.	Yes In child care, exclude until cleared by the LHD. In other settings, exclude until diarrhea has resolved and child is diarrhea-free for at least 24 hours; or until cleared by the LHD.	Emphasize washing hands often, especially after toileting and after diapering; thorough environmental cleaning using bleach or another cleaner effective against this pathogen.		X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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DIARRHEAL ILLNESS: UNKNOWN CAUSE	Varies according to causative agent	Varies according to causative agent. Symptoms might include nausea, vomiting, diarrhea, stomach cramps, headache, blood and/or mucus in stool, fever.	Usually spread from person-to-person by fecal-oral route through direct contact with an infected person or ingesting contaminated food or water.	Duration of clinical symptoms or until causative agent is no longer present in stool.	Exclude until diarrhea has resolved and child is diarrhea-free for at least 24 hours; or until cleared by HCP. If norovirus is suspected, exclude for 48 hours after last episode of diarrhea or vomiting.	Emphasize washing hands often, especially after toileting and diapering; conduct thorough environmental cleaning; individuals should not go swimming if they have diarrhea.			X
DIPHTHERIA (***Coryne-bacterium diphtheriae***)	Usually 2-5 days	Patches of grayish membrane with surrounding redness of throat, tonsils, nose, and/or mucous membranes. May include nasal discharge, sore throat, fever, hoarseness, barking cough. Less common sites of infection: kin, eyes, ears, and vagina.	Spread from person-to-person by contact with respiratory secretions or skin lesions. Rarely, transmission may occur from articles soiled with discharge from lesions of infected persons.	Variable; without antibiotics, usually persists 2 weeks or less and seldom more than 4 weeks. Chronic carriers may shed organisms for 6 months or more. Effective antibiotic therapy promptly terminates shedding.	Yes, until cleared by LHD.	Vaccination; contact LHD for additional guidance.		X	X

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FIFTH DISEASE (Erythema Infectiosum, Parvovirus B19)	Usually <14 days	Fever, runny nose, headache, rash, and joint pain and swelling; rash can be red and patchy facial rash (“slapped cheek”) that may spread to rest of body in lace-like pattern. Cold-like symptoms may precede rash. May be asymptomatic.	Spread from person-to-person through respiratory secretions; by contaminated blood or blood products; from mother to fetus.	Most infectious before the onset of rash; unlikely to be contagious after rash appears	No, exclusion is usually not necessary. Contact HCP and/or LHD about recommendations for infected persons with chronic anemia at risk for hemolytic complications (such as sickle cell disease), weakened immune systems, or for pregnant women.	Encourage hand washing and thorough environmental cleaning.	Pregnant women exposed to a case of Fifth disease should consult with their HCP.		X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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GONORRHEA (***Neisseria gonorrhoeae, Gonococcus***)	Usually 1-14 days	Genital infection can include purulent discharge, painful urination, and lower abdominal pain. Throat and anorectal infections may produce discharge, localized pain. Infection can cause achy, swollen joints; skin rash; and fever. Cases with these signs of disseminated gonorrheal infection require immediate medical attention.	Spread from person-to-person by genital, oral or anal sexual contact	Variable	No, exclusion is not routinely recom-mended.	Cases should contact a HCP, and be referred to the LHD for follow-up. Expedited Partner Therapy (EPT) is the clinical practice of treating the sex partners of patients diagnosed with chlamydia or gonorrhea by providing prescriptions or medications to the patient to take to his/her partner without the health care provider first examining the partner. https://www.cdc.gov/std/ept/default.htm Doxy PEP has proven to reduce the risk of getting a bacterial STI for gay, bisexual, and other men who have sex with men and transgender women at increased risk for these infections (specifically, syphilis, chlamydia, gonorrhea). https://www.cdc.gov/sti/php/from-the-director/doxy-pep-sti-prevention-strategy.html	All cases should be referred to a HCP for assessment (including potential for chlamydial co-infection) and possible treatment. This infection in a child may possibly be an indicator of sexual abuse. Camp operators, health practitioners, police officers, educators, and human service workers are required to report child abuse (COMAR 10.16.06.35, § 5-704).	X	X
HAEMOPH-ILUS INFLUENZAE type B (HIB)	As little as a few days for symptoms to appear, but definitive time is unknown	Symptoms and illness vary depending on the site of infection (pneumonia, bacteremia, meningitis, epiglottitis, cellulitis, infectious arthritis)	Airborne droplets produced by coughing or sneezing or contact with nasal or throat discharges of an ill person or carrier; or by direct person-to-person contact.	Variable	Yes, exclude for 24 hours after the initiation of antibiotic therapy.	Vaccination is the most effective way to prevent infection; contact LHD for recommendations about the need to exclude those who are unvaccinated, or to administer prophylaxis to contacts.	Contagious potential of invasive Hib disease limited; however, close, prolonged contact with an infected person can lead to transmission.	X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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HAND, FOOT AND MOUTH DISEASE **(various Coxsackie-viruses and enteroviruses)**	Usually 3-5 days	Rash on palms, fingers, and soles, and occasionally, on buttocks, knees, or elbows. Fever and painful oral ulcers/sores might occur.	Spread through direct and indirect contact with nasal and oral secretions, aerosol droplets, and feces of an infected person.	Most contagious during the first week of illness. Shedding in stool may continue for several weeks.	No, children can go to childcare and schools as long as they have no fever, have no uncontrolled drooling with mouth sores, sores on the body can be covered, and feel well enough to participate in activities.	Ill individuals and caregivers of ill infants and diapered children should wash hands often and avoid sharing eating utensils; sores should be covered and discharge should be contained with bandages; wash or discard items of clothing contaminated with nose or throat discharges or with fecal material; thorough environmental cleaning using bleach or other cleaner effective against enterovirus.			X
HEPATITIS A	Usually 28 days after exposure; range 15-50 days	Abrupt onset of fever, malaise, loss of appetite, nausea, abdominal discomfort, dark urine and jaundice. In children younger than 6 years of age, infections may be asymptomatic.	Fecal-oral route by either person-to-person contact or ingestion of contaminated food or water. Waterborne outbreaks are infrequent and are usually associated with sewage-contaminated or inadequately treated water.	1-2 weeks before onset of illness; risk minimal the week after onset of jaundice. If no jaundice, then 2 weeks after onset of symptoms.	Yes, children and adults with acute Hepatitis A who work as food handlers or attend or work in child care/elderly settings should be excluded for 2 weeks after onset of early symptoms or 1 week after onset of jaundice.	Improved sanitation (i.e., in food preparation and of water sources) and personal hygiene (i.e., hand hygiene after toileting and diaper changes in child care settings); vaccination; consult LHD for post-exposure prophylaxis with Hep A vaccine and/or immunoglobulin.		X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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HEPATITIS B	Usually 60-90 days; range 45-180 days	Malaise, fatigue, loss of appetite, nausea, vomiting, right upper quadrant abdominal pain, fever, headache, skin rashes, joint stiffness, dark urine, jaundice, and light or gray stools. Infants and children may be asymptomatic.	Spread by exposure to infected body fluids such as via injection drug use, from mother to infant during pregnancy or birth, or sexual contact. Nosocomial transmission is possible through contaminated objects/devices.	People with acute and chronic Hepatitis B infection should be considered infectious any time that HBsAg is present in the blood. Hepatitis B virus can survive on environmental surfaces 7+ days.	No, not routinely recommended; however, exclusion may be considered in cases in which a child's medical condition (oozing sores or rash, bleeding) or behavior (scratching, biting) increases likelihood of exposing others. Contact LHD for additional guidance.	Vaccination; all infants born to HBsAg positive mothers should receive HBIG with the first vaccine dose starting 12 hrs after birth.	[Also, see SHS Guideline "Bloodborne Pathogens Control And Handling Body Fluids in the School Setting".]	X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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HEPATITIS C	Usually 6-9 weeks; range 2 weeks-6 months.	70-80% of acute infections are asymptomatic. However, loss of appetite, weight loss, nausea, vomiting, jaundice, dark urine, fatigue, and abdominal discomfort may occur.	Exposure to infected blood, primarily parenterally (e.g. through injection drug use, needlestick). Sexual and perinatal transmission are rare.	One or more weeks before the onset of symptoms through the acute clinical stage of illness. People who are asymptomatic can still transmit throughout the acute stage of illness. Most people become chronic carriers and can remain infectious indefinitely, if untreated.	No, not routinely recommended; however, exclusion may be considered in cases in which a child's medical condition (oozing sores or rash, bleeding) or behavior (scratching, biting) increases likelihood of exposing others. Contact LHD for additional guidance.	Avoid behaviors that can spread the disease like sharing or reusing needles or other personal items that might come into contact with infected blood.	[Also, see SHS Guideline "Bloodborne Pathogens Control And Handling Body Fluids in the School Setting".]	X	X

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HERPES SIMPLEX VIRUS **(Cold sores, fever blisters, genital herpes sores, skin lesions)**	Usually 2-12 days	Oral herpes: sores or blisters on the lips or mouth Genital herpes: painful sores or blisters in the genital area Herpes gladiatorum: Sores on exposed areas of skin.	Spread from person-to-person by direct contact with saliva, sores, or blisters, such as touching, kissing, or having sex; perinatally.	Virus can be recovered from lesions 2-7 weeks after primary infections and up to 5 days in reactivation lesions	Oral herpes: No, unless the child is drooling and cannot contain secretions or meets other exclusion criteria. Genital herpes: No, unless meets other exclusion criteria. Herpes gladiatorum: Yes, exclusion from contact sport participation that requires skin-skin contact until sores resolve.	Limit skin to skin contact of any type where the lesions are present.	Pregnant women with herpes should consult a HCP. HSV is treatable but not curable.		X

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HIV (Human Immunodeficiency Virus) infection, includes AIDS	Variable; 10-90 days from infection to detection of antibodies. Median incubation in infected infants is shorter than adults.	May be asymptomatic for many years. Symptoms in the early stage of HIV may include flu-like symptoms (fever, cough, body aches, etc.) or be asymptomatic. Symptoms in later stages of HIV infection are variable.	Spread from person-to-person through sexual contact; exposure to HIV-infected blood or body fluids (e.g., contaminated/non-sterile needles); from mother to infant during pregnancy, birth, or through breast/chestfeeding .	Soon after onset of infection and persists throughout life. Infectivity is high during the first months; increases with viral load; worsening of clinical status; and presence of other sexually transmitted infections. Effective treatment eliminates communicability.	No, unless meets other exclusion criteria, has weeping and oozing sores that can not be covered, bleeding condition where blood can not be contained; if so, consult LHD.	Abstinence or condom use; treatment of HIV-positive individuals; PrEP for HIV-negative individuals; routine HIV testing; avoidance of blood and sharps exposures.	Standard precautions should be followed by all HCP. [Also, see SHS Guideline "Bloodborne Pathogens Control And Handling Body Fluids in the School Setting".]	X	X
HUMAN PAPILLOMA-VIRUS (HPV)	Varies (months to years or longer)	Most infections are asymptomatic. Clinical manifestations: anogenital warts, recurrent respiratory papillomatosis, cervical cancer precursors, and cervical, anal, vaginal, vulvar, penile and oropharyngeal cancers.	Most commonly spread during vaginal or anal sex. Also spreads through close skin-to-skin touching during sex.	Transmission may occur from persons with visible lesions and from persons with no clinically apparent disease.	No, unless meets other exclusion criteria.	Vaccination; abstain from sex; delay sexual debut; minimize the lifetime number of sex partners; consistent and correct use of latex condoms may reduce the infection when infected areas are covered by the condom.			

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IMPETIGO (Skin infections, Staphylococcal or Streptococcal skin infections)	Variable, usually 4-10 days	Blister-like skin lesions, which later develop into crusted sores with an irregular outline	Direct contact with draining sores or by touching articles contaminated with blister fluid.	Usually not contagious after 24 hours of treatment	If lesion can be covered, exclusion not recommended. If lesion cannot be covered,, exclusion is recommended. If antibiotic therapy indicated, exclude until 24 hours of antibiotics completed, or otherwise cleared by HCP (in some cases, antibiotic use may not be indicated for treatment). If no antibiotics indicated, exclude until lesion healed. For contact sports: Yes, if lesion cannot be covered, exclude regardless of whether antibiotics started, until lesion is healed.	Cover lesions, avoid touching lesions, practice appropriate personal hygiene; emphasize frequent hand-washing; conduct thorough environmental cleaning; clothing, linens, and towels used by an infected person should be washed every day and not shared.	Cases with lesions should avoid contact with newborns. [See also sections for “Staphylococcal Infection” and “Streptococcal Infection.”]		

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
INFLUENZA (Seasonal)	Usually 2 days; range 1-4 days	Cough, fever, chills, headache, muscle aches, runny nose, sore throat, and, eye pain and sensitivity to light. Nausea, vomiting, and diarrhea are also possible.	Person-to-person by droplets from coughing or sneezing. Less frequently, transmission might also occur through direct contact with contaminated surfaces and then touching the eyes, nose or mouth.	Adults can transmit from the day before symptom onset to approximatel y 5 days after symptoms begin. Children and people with weakened immune systems can shed the virus for longer periods of time.	Yes, until at least 24 hours after fever is gone without the use of fever-reducing medications, and after symptoms have improved.	Vaccination, including for caregivers of children unable to be vaccinated (e.g. infants younger than 6 months); emphasize respiratory hygiene/cough etiquette, frequent handwashing and avoid touching eyes, nose, and mouth; conduct thorough environmental cleaning. Antiviral treatment is recommended as soon as possible for any patient with suspected or confirmed influenza who is hospitalized; has severe, complicated, or progressive illness; or is at higher risk for influenza complications.	Do not use salicylates (such as aspirin) during illness.		X
LICE, BODY (Pediculus corporis)	Varies	Intense itching, worse at night. Lice often live in seams of clothing and may or may not be visible.	Direct contact with an infested person or contact with objects used by an infested person, especially clothing.	As long as lice are alive on infested person or object. Eggs viable on clothing 1 month. Adult lice viable away from the host for up to 2 days.	Yes, at the end of the program/activit y/school day. Skin may need treatment with pediculicide; if one is used, exclude for 24 hours after first treatment is completed.	Bathe with soap and water; wash clothing and bedding in hot water and dry on high heat or dust clothing with a pediculicide.	Body lice may transmit serious infections.		X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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LICE, HEAD (***Pediculus capitis***)	Varies	Often asymptomatic; itching possible. Nits (eggs) are tightly attached to the hair shaft near the scalp, often near the nape of neck and behind the ears. Crawling lice are rarely seen.	Direct contact with infested person's hair or occasionally their clothing, combs, brushes, carpets, or linens. Lice do not jump from person to person.	As long as lice are alive on infested person or object. Adult lice are viable away from the host for up to 2 days.	Yes, at the end of the program/activity/school day, until after the first treatment is completed. For nits, routine exclusion is not recommended. "No-nit" policies are not recommended.	Notify parent/guardian to treat child with a pediculicide and remove nits; do not share combs, brushes, hair ornaments, hats, or linen; examine close contacts for lice and treat; wash clothing, bedding, and towels in hot water and dry on high heat or dry clean or place in tightly closed plastic bag for 14 days; vacuum furniture and rugs.	Exclusion or readmission can be determined by local policy, or on a case-by-case basis. Lice do not transmit any communicable diseases, but bacterial infections of skin can result from scratching.		
MEASLES (Rubeola)	Usually 14 days; range 7-21 days	Typically, illness begins with fever, cough, runny nose, and conjunctivitis. Then, flat red spots typically appear at the hairline and spread downward to the face, neck, trunk, arms, legs, and feet. Small white spots (Koplik's spots) inside the mouth are characteristic of measles.	Primarily person-to-person via infectious respiratory droplets. Airborne transmission in closed areas (i.e., office) for up to 2 hours after a person with measles occupied the space.	From 4 days before to 4 days after rash onset. Immuno-compromised children may be contagious for the duration of the illness.	Yes, until 4 days after the onset of rash in otherwise healthy children and for the duration of illness in immunocompromised children. Contact LHD for additional guidance on management of cases and contacts.	Vaccination; immunoglobulin may be recommended as post-exposure prophylaxis for contacts (consult LHD).		X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

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MENINGITIS, ASEPTIC or VIRAL **(including Enterovirus, Measles, Herpes, Adenovirus)**	Usually 3-10 days	Fever, severe headache, stiff neck, photophobia, drowsiness, confusion, altered mental status, nausea and vomiting may occur. Meningitis symptoms are considered a medical emergency and should be assessed immediately by a HCP.	Varies depending on specific viral agent. Enteroviruses are most often spread through direct contact with respiratory secretions.	Depends on the viral agent causing illness, but usually 3 days after infected until 10 days after developing symptoms.	Yes, until cleared for return by HCP or LHD. Contact LHD for guidance. Contacts of cases generally do not need to be seen by a HCP or given preventive medications.	Emphasize hand washing after use of bathroom, changing diapers, and before handling or eating food or drink; depending on causative agent, may require additional control measures.	Most viral infections do not require treatment; however, some may require specific antiviral therapy.	X	X
MENINGITIS, BACTERIAL **(*Haemophilus influenzae, Neisseria meningitidis, Streptococcus pneumoniae, Listeria*)**	Varies depending on specific bacterial agent, but usually 2-10 days	Abrupt onset of fever, stiff neck, severed headache, vomiting, confusion or altered mental status, and rash may occur. Meningitis symptoms are considered a medical emergency and should be assessed immediately by a HCP.	Primarily spread from person-to-person by direct or indirect contact with respiratory droplets or secretions (i.e., saliva).. Some agents that can cause meningitis are spread from mother to child during birth or by eating contaminated food.	Depends on the bacterial agent causing illness	Yes, until cleared by a HCP in conjunction with the LHD. Contact LHD for additional guidance on management of cases and contacts.	Vaccine-preventable for some types of bacteria that can cause meningitis (Haemophilus influenzae, Neisseria meningitidis, Streptococcus pneumoniae).		X	X

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MENINGO-COCCAL DISEASE (***Neisseria meningitidis***)	Usually 3-4 days; range 2-10 days	Abrupt onset of fever, vomiting, intense headache, photophobia, confusion or altered mental status, and neck stiffness. A rash may appear on the body.	Primarily spread from person-to-person by direct or indirect contact with respiratory droplets or secretions	From 7 days before onset of symptoms, up to 24 hours after the initiation of appropriate therapy	Yes, refer case to HCP.	Vaccination; follow LHD recommendations for prophylaxis and surveillance for close contacts, including household, child care contacts, and others with saliva contact with case.		X	X
MOLLUSCUM CONTAGIO-SUM	Usually 2-7 weeks; range 7 days-6 months	Smooth, spherical papules on skin, sometimes appearing in linear orientation, and can be itchy. In children, lesions are most often seen on the face, trunk, extremities.	Usually through direct skin-to-skin contact, including through objects contaminated with virus, or sexual contact. Auto-inoculation is possible.	Unknown, but likely as long as lesions persist.	No, exclusion is not routinely recommended. For contact sports or sports with shared equipment that comes in contact with skin, exclusion is not recommended if lesions/bumps can be covered with clothing or a watertight bandage.	Lesions not covered by clothing should be covered with a watertight bandage; change the bandage daily or when obviously soiled; frequent hand washing.	Genital lesions in a child may possibly be an indicator of sexual abuse. Camp operators, health practitioners, police officers, educators, and human service workers are required to report child abuse (COMAR 10.16.06.35, § 5-704).		X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
MONONUCLE-OSIS, INFECTIOUS **(Epstein-Barr virus)**	Usually 4-6 weeks	Fever, sore throat, swollen lymph nodes, sometimes rash. Neurologic complications include meningitis, encephalitis, and myelitis.	Primarily spread person-to-person by direct or indirect contact with saliva. Kissing facilitates spread among young adults. Transmission can also occur by blood transfusion.	Prolonged; may be up to a year or more. Some may be long-term carriers.	General exclusion: No, exclusion not routinely recommended. Contact sports: Yes, until acute illness is resolved and cleared by a HCP.	Use general hygienic measures, including handwashing, to prevent salivary contamination from infected individuals; minimize contact with saliva (e.g., avoid drinking beverages from a common container).	Regarding contact sports, HCP must clear athletes to reduce risk of splenic rupture.		X
MPOX	Usually 3-17 days	Rash that may be located on hands, feet, chest, face, or mouth or near the genitals, and can initially look like pimples or blisters and may be painful or itchy. Other possible symptoms: fever, chills, swollen lymph nodes, exhaustion, muscle aches and backache, headache, respiratory symptoms	Direct prolonged, skin-to-skin contact; via oral, anal or genital sexual contact; contact with contaminated fabrics (clothing, towels, etc.), and objects (utensils, cups, etc.)	May spread disease from the time symptoms start until all symptoms have resolved, including full healing of the rash with formation of a fresh layer of skin	Yes, in general, people with mpox should remain in isolation for the duration of illness, typically 2-4 weeks.	Thorough environmental cleaning and disinfection (See CDC guidance for detailed information); vaccination for those who are eligible.		X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
MUMPS	Usually 16–18 days; range 12-25	Malaise, muscle aches, fever, and headache. Parotitis is the most common symptom. May be asymptomatic. Meningitis may occur. In males after puberty, orchitis (inflammation of one or both testicles) may occur.	Airborne transmission or by direct contact with infected droplets or saliva.	Occurs between 2 days before onset of parotitis and 5 days afterwards.	Yes, exclude case for 5 days after onset of parotid swelling. Refer case to HCP and contact LHD for guidance managing contacts of cases.	Vaccination		X	X
PERTUSSIS **(*Bordetella pertussis*, Whooping Cough)**	Usually 7-10 days; range 5-21 days	Gradual onset, similar to common cold, progresses to characteristic paroxysms of many rapid coughs, followed by an inspiratory high-pitched “whoop” sound; may be followed by vomiting and exhaustion.	Respiratory route through contact with respiratory droplets, or by contact with airborne droplets of respiratory secretions	From onset of symptoms through the third week after the onset of cough or until 5 days after the start of effective antimicrobial treatment.	Yes, consult with LHD. Confirmed cases should be excluded until completion of 5 days of recommended antibiotics. Untreated cases should be excluded 21 days from the onset of cough.	Vaccination; consult LHD for post-exposure prophylaxis of close/household contacts, including healthcare personnel.	Highly contagious among unvaccinated children in school, child care, or camp settings. Infants, elderly and immunocompromised individuals are at increased risk for complications.	X	X

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PINWORMS (***Enterobius vermicularis***)	1-2 months	Perianal itching (usually worse at night), irritability, disturbed sleep, secondary infection of the scratched skin	Egg transmission occurs by the fecal-oral route, either directly or indirectly via contaminated hands or objects such as clothes, toys, and bedding, or other contaminated objects. Dustborne infection is possible in heavily contaminated households and institutions.	Eggs survive in the environment at room temperature for about 2 weeks.	No	Wash hands with soap and water frequently, especially after using the toilet, changing diapers, and before handling food; keep nails short; discourage nail biting and perianal scratching. Take the following actions daily for several days after starting treatment: change to clean underwear and bed sheets after bathing; wash linens in hot (131°F) water and dry thoroughly; and clean and vacuum living and sleeping areas.	A HCP should be consulted before treating a suspected case of pinworm infection. All household contacts and caretakers of the infected person should be treated at the same time.		X
PNEUMO-COCCAL DISEASE (***Streptococc-us pneumon-iae***)	Varies depending on type of infection, but can be as short as 1-3 days	Various symptoms, depending on location of infection: ear, eye, sinus, lungs, blood, joints, or spinal fluid spaces; may cause meningitis	Person-to-person transmission through contact with respiratory droplets	Unknown, but may occur as long as the organism remains in respiratory secretions, typically ~24 hours after starting antibiotics.	No, exclusion is not routinely recommended. Contact LHD for additional guidance.	Vaccination; encourage hand hygiene and respiratory etiquette.		X inva-sive disease only	X
POLIO	Usually 7-14 days for paralytic cases; range 3-35 days	Variable; can be asymptomatic, or cause flu-like symptoms, or more severe illness (meningitis, muscle paralysis, death).	Person-to-person via fecal-oral route. Oral-oral route is possible. Asymptomatic persons shed virus in the stool and are able to transmit the virus to others.	Most infectious 7-10 days before and after symptom onset. Virus present in stool 3-6 weeks.	Yes, exclude case until LHD approves readmission. Contact LHD for additional guidance on cases and contacts.	Vaccination		X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
RABIES (and RABIES EXPOSURE)	Variable: Weeks to years	Human: Apprehension, fever, difficulty swallowing, hypersalivation, muscle weakness, hydrophobia, sensory changes (e.g. tingling) or paralysis, delirium, convulsions, and death due to respiratory paralysis. Animal: Unusual behavior changes (stupor or aggression), increased salivation, and paralysis. Death in 2-7 days from onset of clinical signs.	Primarily via bite from a rabid animal. Non-bite exposures include scratches, abrasions, saliva or other infectious material (e.g. brain, nervous system tissues) contamination of fresh, open wounds or mucous membranes, and organ transplantation.	Human-to-human bite transmission does not generally occur. In dogs and cats,approximately 3-5 days before clinical signs appear and throughout the clinical course of disease.	No, exclusion is not recommended for rabies exposure alone.	Do not let children play with unfamiliar animals or have contact with wild animals, especially bats. If a person is exposed to a suspect rabid animal, immediately wash the wound thoroughly with soap and water for several minutes. Seek emergency medical attention immediately if a child was bitten. For school age children, see the SHS Guidelines for Emergency Care in Maryland Schools. For preschool age children, contact the child's HCP. Contact LHD to assess the need for rabies post-exposure prophylaxis (PEP).	Any confirmed or suspected rabies exposure must be reported immediately by telephone to local law enforcement and LHD. Confine the suspect rabid animal (if it is safe to do so) or as advised by local law enforcement, and LHD or animal control, for possible testing or quarantine. For additional information, refer to: https://health.maryland.gov/phpa/OIDEOR/CZVBD/Pages/rabies.aspx [Also, see section for "Bites, Animal".]	X	X

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RINGWORM OF SCALP (***Tinea capitis***)	Usually 10-14 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.	Contact with the skin of an infected person or animal, or by contact with contaminated surfaces or objects such as combs, furniture, clothing, and hats. Infected people may be asymptomatic, yet able to transmit disease.	May persist on contaminated materials for an extended time if untreated.	Yes, until oral treatment has been initiated.If lesion(s) cannot be fully covered, exclude from contact sports involving skin-skin contact until lesion(s) healed.	Cover lesions to prevent direct contact; disinfect sports equipment that comes into contact with skin; avoid sharing sports equipment that comes in contact with skin. Examine household, child care, school, camp, and animal contacts; refer to HCP for treatment if infected. Do not share combs, brushes, hair ornaments, hats, or linens while being treated; haircuts or shaving the head is not needed; selenium-containing shampoo twice a week limits shedding of fungus. Head lesions may not be able to be covered and this should be handled on a case-by-case basis.	Recommended treatment for ringworm of the scalp is oral medications because topical medications are not effective against ringworm of the scalp.Topical medications are considered effective for non-scalp ringworm.		
RINGWORM OF SKIN OR BODY (***Tinea corporis***)	Usually 4-10 days	Lesions are usually circular or ring-like, slightly red with a raised edge, and appear on the face, trunk, or extremities, and may itch.	Contact with lesions or with contaminated surfaces such as floors, showers, or benches	While lesions are visible. Fungus may persist for long periods on contaminated surfaces.	Routine exclusion is not recommended, as long as lesions can be covered, and oral or topical treatment has been initiated. Exclude from contact sports involving skin-skin contact.	Cover lesions to prevent direct contact; disinfect sports equipment that comes into contact with skin; avoid sharing sports equipment that comes in contact with skin; launder towels, linens and clothes in hot water; refer contacts to their HCP; examine skin for resolution of lesions.	Topical medications are considered effective for non-scalp ringworm.		

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ROSEOLA (Human herpesvirus 6, Exanthem subitum, Sixth Disease)	Usually 10 days; range 5-15 days	Fever, rash (small flat pink spots or patches) usually on the chest, back, abdomen, neck and arms; rash not usually itchy.	Direct contact with salivary secretions	Unknown	No, unless meets other exclusion criteria.	No specific control or preventive measures indicated.			X
RSV (Respiratory Syncytial Virus)	Usually 4-6 days; range 2-8 days	Runny nose, sneezing, fever, eating or drinking less, decreased participation in routine activities, cough, which may progress to wheezing or difficulty breathing	Primarily spread from person-to-person by direct or indirect contact with respiratory droplets or secretions	Infected individuals are often contagious from 1-2 days prior to symptoms until 3-8 days after onset. Infants and others with weakened immune systems can spread the virus for several weeks.	No, unless meets other exclusion criteria. Follow LHD recommendations.	Emphasize handwashing hygiene and respiratory etiquette; thorough environmental cleaning.Vaccination to eligible individuals.	Consult HCP immediately if the child is having difficulty breathing, not drinking enough fluids, or experiencing worsening symptoms.		X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
RUBELLA **(German measles)**	Usually 14-17 days; range 14-21 days	Mild illness with low fever, mild rash, and usually enlargement of lymph nodes on back of neck. Maculopapular rash usually occurs on face and progresses down the body.Rash lasts about 3 days, is occasionally pruritic, is often more prominent after a hot shower or bath; fainter than measles rash and does not coalesce.	Spread person-to-person by contact with respiratory droplets and secretions.	Most contagious when rash first appears, but virus may be shed from 7 days before to 5-7 days or more after rash onset. Children with congenital rubella syndrome may shed virus for up to 1 year.	Yes, exclude for 7 days after rash onset. With outbreaks, exclude unimmunized individuals until they are immunized. Contact LHD for additional guidance.	Vaccination		X	X
SCABIES	Usually 2-6 weeks for individuals without previous exposure; 1-4 days for those reinfested	Rapid onset of red papular rash, with or without white scaling, involving the fingers, wrists,elbows, knees, abdomen, armpit, webbing between the fingers, nipple, penis, waist, belt-line, and buttocks. The head, face, neck, palms, and soles often are involved in infants and very young children. Intense itching, especially at night.	Person-to-person through direct skin-to-skin contact such as among household contacts, through sexual contact or through direct contact with contaminated clothes, bedding, and personal articles	Until mites or eggs are destroyed, usually after 24 hours of effective therapy. Mites usually die if away from their host for more than 2-3 days.	Yes, until after treatment is administered. Refer cases and contacts to HCP for treatment and prophylaxis and follow HCP instructions for administration of treatment and after care.	Clothing, bedding and other personal articles used in the 3 days before treatment should be laundered using hot cycles of washer and dryer, or dry-cleaned. Items that cannot be dry-cleaned or laundered can be disinfested by storing in a closed plastic bag for several days to a week. Scabies treatment usually recommended for members of the same household, particularly those who have had prolonged skin-to-skin contact. Treat household members and other potentially exposed persons at the same time as the infested person to prevent possible reexposure and reinfestation.	Mites do not transmit any other communicable disease. Itching may persist for weeks following effective treatment due to allergic reaction; bacterial infections of skin can result from scratching.		X

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STAPHYLO-COCCAL INFECTION **("Staph", Impetigo), including MRSA, (Methicillin-resistant *Staphylo-coccus aureus*)**	Variable and indefinite	Skin and soft tissue infections, such as impetigo, boils, or skin abscesses, occasional invasive disease (e.g. wound infections, bloodstream infections, pneumonia)	Direct person-to-person contact, usually on hands. Possible transmission via air, contaminated surfaces, objects. Non-intact skin increases risk.	As long as purulent lesions continue to drain; sporadic cases can occur due to asymptomatic carrier state.	If lesion(s) can be covered, no. If lesion(s) cannot be covered, yes. If antibiotic therapy is indicated, exclude until 24 hours of antibiotic therapy completed, or otherwise cleared by HCP (in some cases, antibiotic use may not be indicated for treatment). If no antibiotic therapy is indicated, exclude until lesion is healed. For contact sports: Yes, if lesion cannot be covered, regardless of whether antibiotics have been started, until lesion is healed.	Avoid touching lesions; emphasize frequent handwashing; conduct routine environmental cleaning.	Colonization alone with Staph, including MRSA, is not a reason for exclusion. Contact LHD for guidance. Antibiotic treatment may not be indicated for every case of Staph infection, including MRSA.		X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
STREPTO-COCCAL INFECTION (Noninvasive disease caused by Group A strep (GAS), e.g. Strep Throat, Scarlet Fever, Impetigo)	Varies by presentation; usually 1-3 days for pharyngitis and 7-10 days for impetigo	Strep throat: Fever and sore throat/ tonsillitis with tender, enlarged lymph nodes. Scarlet fever: sore throat, fever, plus a red rash that feels like sandpaper and lasts 2-5 days. Tongue may appear strawberry- like. When rash fades, skin peels from tips of fingers and toes.	Spread from person-to-person by respiratory droplets and secretions, and by direct contact with cases; rarely, spread can occur by contact with contaminated objects or food.. Carriers are capable of spreading illness.	10-21 days if untreated. Until 24 hours after the start of antibiotic treatment.	Yes, exclude until 24 hours after the start of antibiotic treatment.	Emphasize respiratory etiquette and frequent handwashing.	[Also, see the section for Impetigo (“Skin Infections”).]		X
SYPHILIS	Usually about 3 weeks; range 10 days-3 months	May be asymptomatic; painless ulcer on genitals, anus, or mouth. In the secondary stage, rash on palms and soles, generalized rash, or generalized lymph node swelling may appear.Untreated syphilis in an infant can cause cataracts, deafness, or seizures, and death.	Spread by genital, oral or anal sexual contact with an infected person; from mother to infant during pregnancy or at delivery	Up to one year if untreated but recurrences of lesions may persist	No, exclusion not routinely recommended. For contact sports or sports with shared equipment that comes in contact with skin, exclusion is not recommended if lesions/bumps can be covered with clothing or a watertight bandage.	Should be managed by a HCP. Case should be treated with antibiotics, and sexual contacts examined and treated with preventive antibiotics. Doxy PEP has proven to reduce the risk of getting a bacterial STI for gay, bisexual, and other men who have sex with men and transgender women at increased risk for these infections (specifically, syphilis, chlamydia, gonorrhea). https://www.cdc.gov/sti/php/from-the-director/doxy-pep-sti-prevention-strategy.html	Untreated syphilis can cause serious damage to heart, brain and other organs. Infection in a child may possibly be an indicator of sexual abuse. Camp operators, health practitioners, police officers, educators, and human service workers are required to report child abuse (COMAR 10.16.06.35, § 5-704).	X	X

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TETANUS	Usually 3-21 days; range 1 day to several months Tetanus neonatorum: range 3-28 days	Three clinical forms: Generalized (most common) - presents with a descending pattern; first sign is lockjaw, followed by neck stiffness, difficulty swallowing and rigidity of abdominal muscles. Local (uncommon) - persistent contraction of muscles in the same body part of the injury. Cephalic (rare) - associated with middle ear infections.	Tetanus spores are ubiquitous in the environment; transmission can occur when spores are introduced into a wound, such as a puncture, cut, or burn.	Not contagious from person-to-person.	No	Vaccination; injury prevention; wound care; and proper biohazard waste disposal.		X	

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
TICKBORNE ILLNESSES: **(Anaplasmosis, Ehrlichiosis, Lyme Disease, Rocky Mountain Spotted Fever, etc.)**	Usually 7-14 days; range 2-32 days after tick bite	Fever, headache, lack of appetite, nausea, vomiting, muscle aches, chills; possible swollen lymph nodes,conjunctivitis, or meningo-encephalitis.. Lyme disease, Southern tick-associated rash illness (STARI), Rocky Mountain spotted fever (RMSF), ehrlichiosis, and tularemia can cause distinctive rashes.	Tick bite; rarely through blood transfusion	No documented person-to-person transmission	No	Avoid exposure to potentially tick infested areas; wear protective light-colored, long sleeve shirts and pants; use EPA approved insect repellents; conduct regular tick checks, and shower and tumble dry clothes in a dryer on high heat for 10 minutes after spending time in tick habitat. Remove embedded ticks promptly with tweezers. Consult a healthcare provider if symptoms occur.	Tickborne diseases carry the risk of more severe and/or chronic illness for immunocompromised persons. Pregnant women bitten by a tick should consult with their healthcare provider. Additional information: https://health.maryland.gov/phpa/OIDEOR/CZVBD/Pages/tickborne_dz.aspx	X	

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
TUBERCU-LOSIS **(TB, *Mycobacterim tuberculosis*)**	Usually 2-10 weeks after exposure to someone with active TB who is infectious	Fever, weight loss, malaise, cough and night sweats are common, but some individuals have no symptoms at all. Children younger than 5 years are more likely to present with weight loss, malaise, and failure to thrive.	Airborne via activities such as coughing, speaking and singing. Any procedure that can cause aerosolization of TB droplets may also lead to transmissison, including bronchoalveolar lavage, wound irrigation, etc. Transplanted organs have also been associated with human transmission.	A person diagnosed with active TB on appropriate antibiotics may become non-infectious within a few days to weeks depending on severity of disease and response to treatment. Requirements for isolation from others will vary; instructions by the LHD should be followed.	Children with active TB should be excluded until treatment is started and cleared by LHD. The local TB Control Program will determine when a person with active TB disease may return.	The local TB Control Program will determine control measures in the school,child care, or camp setting.	Facility must cooperate fully with the LHD in testing any other children, faculty,staff, and child care providers to determine if TB transmission has occurred. Requirements for TB testing of new students may vary from one jurisdiction to another. Consult LHD for further details. Children diagnosed with latent TB infection cannot infect others and should not be excluded. Children who have received BCG vaccine might still become infected with TB, and should be included in any testing that the LHD does as part of a TB investigation.	X	X

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
TYPHOID FEVER AND PARA-TYPHOID FEVERS (***Salmonella*** **Typhi,** ***Salmonella*** **Paratyphi)**	Typhoid Fever: Usually 8-14 days; range 3-60+ days Paratyphoid fevers: usually 1-10 days	Fever, headache, malaise, and red ('rose') spots on the body; lack of heart rate elevation with fever; constipation more often than diarrhea	Primarily spread through ingestion of food or water contaminated by the feces or urine of an infected individual. Most often associated with international travel to endemic areas. Sexual transmission has been documented.	For as long as an infected person carries bacteria in feces or urine; if untreated, can be months; if carriers, can be years.	Yes, in childcare, exclude until cleared by LHD after further testing. Contact LHD for guidance. In other settings, exclude until diarrhea has resolved and child is diarrhea-free for at least 24 hours; or until cleared by the LHD.	Encourage hand hygiene after toilet use, after diapering children, and before preparing or eating food. Vaccination can help to prevent infection.		X	X

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
UPPER RESPIRATORY INFECTION (Common Cold and Influenza-like Illness)	Usually 2 days; range 12 hours-5 days, varying with the agent.	Runny nose, watery eyes, sneezing, chills, sore throat, cough, and general body discomfort. Fever might or might not be present. Generally, fevers are more common in children under 3.	Direct contact with an ill person or respiratory droplets; also by contact with hands or articles contaminated with nose or throat secretions.	Variable, depending on cause; average 24 hrs before to 5 days after symptoms have started.	Exclude if fever is present or if the child meets other exclusion criteria (see “General Considerations ” above, or condition-specific recommendations in this document). Do not exclude solely on the presence of runny nose regardless of the color or consistency of the nasal discharge, or presence of cough.	Emphasize covering nose and mouth when coughing/sneezing; using facial tissue to dispose of nose or throat secretions; washing hands often and not sharing eating utensils; increase environmental cleaning.	Many different agents can cause the common cold and influenza-like illness.		X[1]

[1] Outbreaks of influenza-like illness (ILI) are reportable; outbreaks of cold-like illness are not. ILI is defined as a respiratory illness with a temperature of 100°F (37.8°C) or greater orally PLUS cough or sore throat.

Communicable Diseases Summary: Guide for Schools, Child Care, and Youth Camps

Disease/ Condition	Incubation Period	Symptoms	Mode of Transmission	Period of Communi-cability	Exclusion	Prevention and Control Measures	Other Information	Report Case to LHD	Report Outbreak to LHD
VARICELLA ZOSTER VIRUS: CHICKENPOX **(Primary varicella zoster virus infection)**	Usually 14-16 days,range: 10-21 days . May be prolonged in immuno-com promised patients and those who have received postexposure treatment with a vaccine-antib ody containing product.	Fever and malaise may occur 1 to 2 days before rash, especially in adults. In children, rash is often first sign. itchy skin rash progresses rapidly from flat to raised to fluid-filled vesicles before crusting, and is present in all stages of development at same time. Rash generally appears on chest, back and face first, before spreading over entire body. New vesicles can continue to appear for 4-7 days. Scratching may produce skin abrasions and lead to secondary infection.	Person-to-person, by respiratory or airborne droplet spread (produced by talking, coughing, or sneezing) or by direct contact with vesicle fluid, respiratory sections, or mucous membranes of infected persons.	Highly contagious. 1-2 days before the rash appears, until all lesions are completely crusted over (~ 5 days). Persons who are susceptible to varicella should be considered to be infectious from 8-21 days after exposure. Persons with weakened immune systems may be communicabl e for longer periods.	Yes, until all lesions are completely dried or crusted over, usually 5 days after the onset of the rash, may be a week or longer in immuno-compr omised individuals. Lesions that can be fully covered are of little risk to susceptible persons.	Vaccination; contact HCP for additional guidance on post-exposure prophylaxis with vaccine or varicella-zoster immune globulin; disinfect articles handled by, or contaminated with respiratory secretions or vesicular fluid from infected persons.	Advise parent, guardian, or staff member to contact HCP after varicella exposure of neonate, pregnant woman, or an immunocompro mised person. A susceptible person may also acquire chickenpox infection if exposed to the vesicle fluid of someone with shingles (also known as “zoster”). Shingles is also caused by varicella zoster virus (VZV). After a person recovers from chickenpox, the virus stays dormant (inactive) in their body, but can reactivate later, causing shingles.		X

Resources

- For questions about this Summary, contact your LHD, or the MDH Infectious Disease Epidemiology and Outbreak Response Bureau at 410-767-6700.

- Directories of LHDs:
  https://health.maryland.gov/phpa/IDEHASharedDocuments/Maryland-Local-Health-Department-Contact-Information.pdf
  https://health.maryland.gov/phpa/OIDPCS/CSTIP/Pages/LHDs.aspx

- MDH: https://health.maryland.gov/

- CDC: www.cdc.gov

- Control of Communicable Disease Manual: https://ccdm.aphapublications.org/doi/book/10.2105/CCDM.2745