New Mexico Department of Health (NMDOH)'s Epidemiology and Response Division (ERD) 24/7 call line: (505) 827-0006.

Infectious diseases occur frequently in the school setting and sometimes result in disease outbreaks with subsequent need for treatment, surveillance, and contact tracing.

Medical events with community-wide consequences occur hundreds of times each year in New Mexico, some in the school setting. In such cases, there are resources available 24 hours a day, seven days a week through the NMDOH Epidemiology and Response Division (ERD). ERD provides expert consultation through a telephone call line linked to health professionals experienced in management and control of outbreaks as well as assistance with laboratory testing protocols and obtaining vaccines and/or prophylactic medications.

This system is required by New Mexico statute and administrative code. Physician offices, laboratories, and other health care agencies are required to report suspected or actual cases of notifiable diseases to the NMDOH.

Under the same statutes and rules, the NMDOH is required to identify and control outbreaks of these diseases and to report this information to the Centers for Disease Control and Prevention (CDC) as a part of national data collection. Reports from health care providers to the NMDOH are forwarded to the CDC as New Mexico data.

To report a notifiable disease, receive expert consultation and support during a potential outbreak, or to speak with an epidemiologist, call (505) 827-0006.

Notifiable Conditions in New Mexico

Please see this link in the Manual for Investigation and Control of Selected Communicable Diseases for the list of notifiable conditions in New Mexico.

Reportable Communicable Disease Algorithm and NMDOH Contact List

Map of School Health Advocates

Procedures for Control of Communicable Diseases

Classroom Cleanliness

Definition: Maintaining cleanliness to prevent the transmission of communicable diseases in the classroom.

Guidelines

- Adequate hand-washing facilities should be available to students and staff. This includes a sink, hot and cold running water, liquid soap, and disposable paper towels. Provide separate storage areas for clean clothing and linens apart from soiled clothing and linens.
- All soiled disposable items should be held in waste receptacles lined with plastic bags, which should be discarded by staff twice daily. **THESE PLASTIC BAGS SHOULD NEVER BE REUSED!** Contaminated items, including disposable diapers, should be placed in a separate plastic before being discarded in an uncovered waste receptacle.
- Approved bactericidal solutions should be used to clean toys, tables, chairs, and other environmental surfaces. A solution of 1:9 bleach may be used (one part household bleach to nine parts water), but it must be mixed fresh weekly if stored in an opaque container or daily if in a clear container to maintain efficacy. All disinfectants should be properly labeled and stored safely out of reach of students.
- Only washable toys should be available in the classroom.
- All equipment, toys, tables, chairs, mats, therapy equipment, etc., used by students who drool or mouth them should be washed with appropriate disinfectant at the end of each day or before use by another student.
- The use of non-washable furniture and equipment in the classroom is **STRONGLY DISCOURAGED**.
- Wheelchairs and trays must be washed with soap and water after feeding. If students eat in the classroom, all soiled tables and chairs should be cleaned.
- Physical or occupational therapists should be contacted before cleaning orthopedic equipment such as braces, splints, etc. to be sure disinfectant choice is appropriate.
- The sink area should be cleaned with disinfectant at the end of each day. **NEVER** scrape food into the sink or rinse soiled dishes in the sink. Food should be returned to the school cafeteria or scraped into plastic bags and discarded into a waste receptacle.
- All eating utensils and equipment should be washed in a dishwasher. They should be collected in a washable container and taken to the kitchen as soon as possible. Clean dishes should be transported back to the classroom in a clean container.

- Adaptive feeding equipment and other non-disposable dishes should be kept in a clean storage area.
- Students' personal grooming items should be kept in separate containers.
- Soiled rugs or carpet should be cleaned immediately and not be used until the area is dry. Students who are unable to control body fluids should **NEVER** be placed directly on a carpet/rug but should be placed on a washable mat or blanket. Diapering should **NEVER** be done on carpet or a rug.
- Changing tables, portable potties, and toilet seats should be nonporous and be cleaned with approved disinfectant after each use. Portable potties should be emptied into the toilet and disinfected after each use.
- All toilets, potties (both seats and bowls), sinks, diaper changing tables, and floor around changing mat should be disinfected daily. Tile areas of the classroom floor should be wet-mopped with disinfectant daily in classrooms where students eat and when the floor becomes soiled with body fluids. Routine carpet care/shampooing should be provided as needed but at least twice a year.

Classroom Cooking

Definition: Preparing food for the purpose of teaching students cooking skills or meeting other educational goals.

Guidelines

- Before use in classroom cooking, tables and work areas should be cleaned with an approved disinfectant such as a fresh solution of 1 part chlorine bleach to 10 parts water. (If an opaque container is used, the solution needs to be changed weekly; if a clear container is used, the solution must be changed daily to maintain efficacy.)
- Students and instructional personnel should wash hands with soap and water before and after handling food. This process must be repeated any time a student leaves the activity or puts hands to mouth, nose, or perineal area.
- Students who have illness symptoms or who drool excessively should be excluded from the cooking activity.
- It is recommended that disposable scoops, spoons, tongs, and gloves for handling food be used as often as possible and that disposable dishes and dinnerware be used for serving food.
- Students should not be allowed to use fingers to taste food from the preparation bowls.
- Leftovers should be properly stored or disposed of and not left out in the classroom or in the trash can overnight. Food should not be disposed in the sink. Food from dishes should not be rinsed in a classroom sink unless the sink is equipped with a garbage disposal.

- Any non-disposable dishes, pans, utensils, and adaptive equipment should be washed in a dishwasher or in the school cafeteria or kitchen.
- Tables and work surfaces used in any cooking activity should be cleaned as in step one above. All individuals participating in the cooking activity should wash hands as in step two.

Diapering

Definition: Changing diapers in such a way so that potential for communicable disease transmission is decreased.

Guidelines

Students who are not toilet-trained should be checked at least every 2–3 hours and changed when soiled.

Assemble the following equipment.

- Wet disposable towelettes.
- Dry disposable towels/pads.
- Disposable diapers.
- Covered waste receptacle lined with plastic bag.
- Small plastic bag for disposing of diapers if they contain feces or blood.
- Disposable gloves.
- Washable changing table.
- Disinfectant for cleaning changing table.
- Place student on changing table with a nonporous surface in the bathroom or other appropriate setting. Diapers should **NEVER** be changed in the classroom.
- **A STUDENT SHOULD NEVER BE LEFT UNATTENDED ON THE CHANGING TABLE.**
- Place disposable pad, towel, or paper under student's buttocks. Remove clothing or lift as necessary to assure all clothing is above the area of the navel.
- Use disposable gloves according to universal precautions.
- Remove diaper and discard directly into waste receptacle or plastic bag. **NEVER** place a soiled diaper on the floor, carpet, or furniture.
- Wash the perineal area with disposable towelette. With girls, wash from top to bottom and discard towel after each stroke to prevent organisms from entering the vaginal or bladder area. Dispose of towelette with diaper. Place clean diaper on student.
- Remove dry towel from under student. Remove disposable gloves. Discard into waste receptacle.
- Wash student's hands before returning him/her to class.
- Wash changing table with disinfectant.

Wash hands according to hand-washing procedure described in this section.

Hand-washing

Purpose: Hand-washing is one of the most effective techniques in preventing transmission of infectious diseases.

Guidelines

Hands should be washed with soap:

- Before eating and drinking.
- Before handling dining equipment or utensils.
- Before and after handling any food.
- Before and after assisting in toileting, diapering, or feeding.
- After contact with body fluids or blood.

Remove rings and bracelets before hand-washing because microorganisms hide under jewelry.

Recommended procedures for hand-washing:

1. Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap.
2. Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails.
3. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
4. Hold hands so that water drains from wrist area to fingertips and rinse well under clean, running water.
5. Dry your hands using a clean towel or air dry them. Turn the faucet off with a towel and then discard towel in wastebasket.
6. Apply lotion as desired to prevent chapping, because chapped skin breaks open easily, permitting bacteria to enter the system.

To access curriculum, posters, brochure, etc. on hand-washing for use in the school setting go to:

- Hand Hygiene in School and Early Care and Education | CDC.
- When and How to Wash Your Hands | Handwashing | CDC.
- Show Me the Science – How to Wash Your Hands.

Bloodborne Pathogens Exposure Risk

Chapter 17 of this Manual contains the OSHA reference guidelines, a sample school exposure plan, and training material. Federal requirements can be accessed through the OSHA website at Bloodborne Pathogens and Needlestick Prevention.

Toileting

Definition: Training, monitoring, and/or assisting a student with toilet needs when the student is unable to do this independently, decreasing the risk of spreading diseases through fecal-oral contamination.

Guidelines

- Assemble all equipment.
- Suitable sized and adapted toilet/portable potty.
- Toilet tissue or disposable towelettes.
- Covered, plastic-lined waste receptacle.
- Disinfectant.
- Disposable gloves.
- Disposable plastic bag.
- Clean diaper if necessary.

Hand-washing by both the student and supervising adult is the most effective method to remove any fecal contamination before the student is returned to class.

Communicable Diseases Information Sheets

Introduction

Communicable Diseases Information sheets are designed to be used as educational and informational material for students, staff and parents, particularly when outbreaks occur in the school setting.

Disease fact sheets in English and Spanish are linked, where available, under each condition. They can also be found in the Manual for Investigation and Control of Selected Communicable Diseases in New Mexico.

More in-depth information on common diseases encountered in the childcare settings can be found in the Communicable Diseases in Child Care Settings section.

Another good resource for disease-specific information is the CDC Index to Diseases and Conditions: https://www.cdc.gov/DiseasesConditions/.

Several general methods of disease prevention are listed below:

Medical Evaluation – referral of possible cases to a healthcare professional for diagnosis and treatment.

Reporting to the NMDOH – see list of reportable conditions; reports can be made to the Regional Health Officer or to the Epidemiology and Response Division hotline at (505) 827-0006. Immediate reporting of highly contagious diseases like measles and shigellosis, serious conditions such as meningitis, and outbreaks of gastroenteritis (vomiting or diarrhea) that may be due to a food or waterborne disease are especially important. A list of reportable conditions is posted at this site.

Contact Prophylaxis – some infections that are likely to affect close contacts of cases may be preventable by prophylaxis (preventive treatment). Such treatment may be recommended by the NMDOH to close contacts.

Isolation – refers to the exclusion (e.g., from school) of a person with a communicable disease during the period when they are contagious.

Standard Precautions – an infection control practice that considers all persons' blood and body fluids potentially infectious. Thus, it is not necessary to know if a person has a particular disease to protect oneself from exposure. Practices include avoidance of contact with blood, body fluids and excreta; wearing gloves when contact might occur; frequent hand-washing; and frequent washing and decontamination of counters, sinks, play areas, toys, etc.

Immunization – some vaccine-preventable disease outbreaks occurring in schools have been controlled by school-based immunization programs. Immunization programs in schools also offer protection to older students before they leave the "captive population" of the school.

Prevention Education – schools can model, teach, and reinforce the simple habits of personal hygiene, environmental cleanliness, and safe food-handling procedures that promote good health and minimize exposure to infectious diseases.

Fever – according to the American Association of Pediatrics, "While the average normal body temperature is 98.6°F (37°C), a normal temperature range is between 97.5°F (36.4°C) and 99.5°F (37.5°C). Most pediatricians consider a temperature above 100.4°F (38°C) as a sign of a fever" (American Academy of Pediatrics, Signs and Symptoms of Fever).

Each specific condition includes the following topics:

Disease/Condition	Proper and commonly used name of the disease or condition.
Agent	Name of the infectious agent and its categorization (viral, bacterial, fungal, parasitic).
Clinical Description	Mechanism by which the disease is produced, typical symptoms and complications.
Transmission/ Exposure	**Modes of Transmission**

	Direct: Individual to individual, such as exchange of body fluids, exposure to droplets from the nose or mouth or hand-to-hand contact. Indirect: From an inanimate object, such as hard surfaces, tissues, or dishes. **Routes of Exposure** Inhalation: Airborne (from a sneeze or cough). Contact: Contact with body fluids through an opening in the skin, mucous membrane, sexual contact, or contaminated equipment. Ingestion: Swallowing. Intermediary: A vector-born transmission, such as flea, mosquito, or rodent.
Contagious Period	Period of time that the infectious agent can be passed to another person. Some infections are subclinical (do not produce symptoms), but the person may still be contagious. A carrier state is when the agent continues to be present in a contagious form after the acute stage has passed.
Incubation	Period of time between exposure to an infectious agent and the onset of symptoms.
Diagnosis	Method by which the cause or nature of a disease or condition is determined [clinical diagnosis made by history and physical examination; laboratory diagnosis by lab testing].
Management of Case	Steps to be taken in diagnosis and treatment of the person with the condition, including a requirement for exclusion from school.
Management of Contacts	Steps to be taken in prevention of infection in persons who have been exposed to infection.
Immunization	Availability and recommended use of vaccines and their impact on disease control.
Public Health Action	Requirement for reporting to the NMDOH and the action to be taken by the NMDOH.

Prevention Education	Information on behaviors that individuals can adopt to reduce exposure to communicable diseases.
School Action	Summary of actions by schools to manage communicable diseases in the school community.

Animal or Human Bite Infection

Condition, Disease, Agent	**ANIMAL or HUMAN BITE INFECTION** Bacterial agents include *Streptococcus, Staphylococcus, Pasteurella, Bartonella* (cause of cat-scratch fever); viral agents include herpes simplex, hepatitis B and C, rabies**.**
Clinical Description	An infected bite wound may cause increasing pain and swelling, redness, warmth, and discharge of pus or bloody/serous fluid. Herpes simplex infections of these wounds show blisters and ulcers.
Transmission/ Exposure	Bacteria or virus present in the mouth or throat of a person or animal inoculated into a bite or scratch contaminated with saliva.
Contagious Period	Bacteria, herpes simplex, and other viruses can be carried indefinitely by a healthy person or animal. Rabies virus is present in saliva for a few days before the onset of symptoms.
Incubation	Depends on agent: 1–5 days for bacteria or herpes simplex virus, several weeks for cat scratch fever, weeks, or months for hepatitis B, for rabies 4–6 weeks with range of 5 days to one year.
Diagnosis	Cultures or serologic tests are required to determine the specific cause.
Management of Case	First aid for all bites using standard precautions is very important. Wash the wound with antibacterial soap and rinse well with fresh water. Control bleeding with local pressure over a clean cloth or sterile gauze dressing. Cover wound with a loose sterile dressing. Refer to a provider for further management.

	Report all animal bites to the local Animal Control Officer and provide the name, age, home address, and phone number of the victim as well as a description and location of the animal. Do not kill the animal unless necessary to protect the safety of human or other domestic animals. If it is necessary to kill the animal, attempt to preserve the head and brain intact for rabies testing. Consider evaluation for tetanus and possible immunization.
Management of Contacts	For human bites, review the health and immunization records of the biter and the victim. If the victim has been immunized against hepatitis B, it is very unlikely that he/she would be infected regardless of the infection status of the biter. If preventive treatment for hepatitis B is needed, it should be given as soon as possible.
Public Health Action	• Report animal bites to your local Animal Control Officer as described above. Report bat exposures including potential bites or any handling to your Animal Control Officer. • Reporting to NMDOH is not required. • Contact your regional School Health Advocate and/or your regional Nurse Epidemiologist with questions or concerns. • Contact the NMDOH Epidemiology and Response Division at (505) 827-0006 for questions or concerns regarding potential exposure to rabies, especially bat or wildlife exposures.
Prevention Education	Teach children to avoid unfamiliar domestic animals and all wild or stray animals. Children should not feed or handle animals. Ill or injured animals present special hazards.
School Action	• Apply first aid for wounds and possible shock. • Clean and bandage wound and refer victim to physician or emergency facility. • Report animal bites and stray or injured animals to NM Epidemiology and Response Division (ERD) at (505)-827-0006 and they will advise whether to contact your Animal Control Officer (as described above). • Offer prevention education.

Bed Bugs

Disease/Condition	Bed Bugs in the school setting.
Pest	• Bed Bugs are a worldwide issue. They can be found in five-star hotels and resorts, single family homes, dormitories, nursing homes, schools, and daycare centers. • Bed bugs are very small reddish-brown, wingless insects that feed on warm-blooded animals. • Bed bugs typically feed on humans. However, they can feed on other mammals and birds if there is no human host. • Bed bugs typically will feed on a host's blood during sleep. https://webnew.ped.state.nm.us/wp-content/uploads/2017/12/SHSB_NMAC6.29-1.9.Standards.for_.Excellence_Pest.Control.pdf
Clinical Description	• Itching and irritation of skin • Welts on body typically the face, neck, arms, hands, and feet. • Rust colored spots found on bedding and blankets caused by blood-filled fecal matter excreted by bed bugs • Bed bugs or exoskeletons of bed bugs found on folds of mattress and sheets. • Sweet-musty odor that develops in your bedding.
Transmission/ Exposure	• Bed bugs are not known to transmit disease and students should not be excluded from school due to bed bugs. • Bed Bugs are usually spread by traveling in clothing, baggage and other items from an infested area. • High risk areas for bed bug infestation include accommodations with rapid turnover like motels/hotels, low income housing, shelters, public transportation and even movie theaters. • They hide during the day in crevices of furniture and walls, usually found to be within 8 feet of where people sleep. • Transmission and infestation are NOT related to personal hygiene or cleanliness of the infested site.

Contagious Period	• Period of time that the infectious agent can be passed to another person. • Some infections are subclinical (do not produce symptoms), but the person may still be contagious. • A carrier state is when the agent continues to be present in a contagious form after the acute stage has passed.
Incubation	Eggs hatch after 4-12 days and go through 5 nymphal stages before becoming an adult. They need to feed on blood at all stages after they hatch. Females lay about 5 eggs daily as adults. Adults live 6-12 months.
Diagnosis	To help identify it may be necessary to collect a specimen(s) if possible, using tissue or gauze for confirmation by a professional exterminator/pest management company.

Management of Case	• https://www.epa.gov/ipm/bed-bugs-and-schools
	• Microsoft Word - CCBBTF Bed Bugs in Schools2.doc (fsu.edu)
	• **Bed bug care for a student identified with bed bugs.**
	  ○ Using discretion, remove the student from the classroom so the school nurse or qualified staff can perform inspection of student's clothing, and belongings brought to school. To include: backpacks, shoes, jackets, books, hats, lunch boxes, and other school supplies.
	  ○ The use of discretion and confidentiality is important to minimize social stigma and potential ramifications
	  ○ Staff should make effort to prevent psychological trauma by being aware of and/or recognize potential signs of distress or adverse reactions in children affected. Referral to School behavioral team should be made if staff become aware of any behavioral health problems.
	  ○ Please be advised that the Isolation of students personal belongings could have an adverse effect on their mental well-

being. More discretion should be taken when responding to care of students belongings.
- Bed bugs should be placed in tightly sealed bag and discarded in an outdoor trash receptacle or dumpster.
- If a specimen is found on the student or the student's belongings, remove the specimen and parents should be notified immediately by the school nurse or school administrator if the specimen is a confirmed bed bug (see below). The student does not need to go home, however parents must be notified.
- If identified, place any items not essential for use during the school day in a large plastic bag and tightly seal the bag.
- If available, the school may wash the student's clothing in school washer at the highest recommended setting and tumble dry on high for at least 30 minutes (120^{O}F or above).
- Check all areas where the student has their belongings or sits throughout the day for any extended period.

Remember a single bed bug is not an infestation. Treat only if there is evidence of breeding bed bugs in the school setting.

Recommendations for parents/guardians of student with identified bed bug:

- Advise parent or guardian to send student with extra set of clean, freshly laundered change of clothes. Remind guardian that the clothes should be washed at hottest recommended setting and tumbled dried on high heat for at least 30 mins prior to placing in bag.
- Parents should also send only essential items to school with the student. Advise student to come to health office or administration for inspection; or the school may offer to keep non-essential items with no evidence of bed bugs overnight to keep them bed bug free.
- Suggest keeping school items in sealed plastic bag at home and/or limiting items that go back and forth from school to home until the infestation at home is under control.
- Recommend storing the student's items (coat, backpack, lunch bag, etc.) separate from those of other classmates. If feasible, individual plastic containers labeled with student's name can also be used.

- Vacuum areas where bed bugs can be found (mattresses, couches, and floor and baseboards).
- Remove vacuum bag or contents of the bag-free vacuum container and place in a tightly sealed plastic bag. Dispose of the bag in an outdoor trash can.
- Change vacuum bag before vacuuming any uninfected areas.
- If true infestation is confirmed parents should contact local Integrated Pest Management (IPM)

If staff identify a possible bed bug infestation here are some recommendations for school nurse and other staff.

- Identify the exact location and isolate area. It may be necessary to temporarily remove students from the area.
- Contact Integrated Pest Management company or your districts facilities department to see if they currently have a contract with a local company. Integrated Pest Management (IPM) program should be implemented to help maintain pest control. A licensed pest control company can help positively identify and treat appropriately. Your school administration should be a part of overseeing any pest management. https://webnew.ped.state.nm.us/wp-content/uploads/2017/12/SHSB_NMAC6.29-1.9.Standards.for_.Excellence_Pest.Control.pdf
- If possible, attempt to capture one bug for identification by capturing with tissue or gauze. Do not attempt to crush, and place in a sealed plastic bag. Bugs not being kept for identification should be captured, placed in a tightly sealed bag and placed in a outdoor trash receptacle or dumpster.
- Remove any clutter and trash from the area.
- Vacuum all areas where any bed bugs were found and make sure all carpeted, none carpeted, and baseboards are included.
- All contents of the vacuum bag or contents of the bag -free vacuum container should be placed in a tightly sealed garbage bag for disposal in an outdoor trash receptacle or dumpster.
- To minimize potential transfer of bed bugs or eggs it is recommended to store each students' items (coat, backpack, hat, lunch bag, etc.) separately from other classmates. Individual plastic containers can be sued.

Management of Contacts	Staff may inspect area discretely for any signs of bed bugs transferred to belongings of other students. **Remember a single bed bug is not an infestation. Treat only if there is evidence of breeding bed bugs in the school setting.**
Immunization	Availability and recommended use of vaccines and their impact on disease control.
Public Health Action	• Reporting to NMDOH is not required. • Contact your regional School Health Advocate and/or your regional Nurse Epidemiologist with questions or concerns. • Contact the NMDOH Epidemiology and Response Division at (505) 827-0006 if the number of cases of bed bugs suddenly increases above what is normally observed in the school's population.
Prevention Education	See Management of Case & Transmission/Exposure sections above.
School Action	See Management of Case above.

Chicken Pox (Varicella)

Condition, Disease, Agent	**CHICKEN POX (VARICELLA)** Varicella zoster virus (human Herpesvirus 3) https://www.nmhealth.org/publication/view/general/5146/ Chicken Pox Fact Sheet, English Chicken Pox Fact Sheet, Spanish
Clinical Description	Fever, malaise, and non-descript respiratory symptoms (usually including cough) 1–2 days, followed by crops of skin lesions. Each lesion evolves from a flat to a raised pink spot to a vesicle (a tiny blister) on a pink or red base ("dewdrop on a rose petal"), pustule (pimple), and crusted pustule. Lesions appear first on the face (behind ears) and trunk spreading to extremities; they may involve eyes and mucous membranes. The rash is usually quite

	itchy. Impetigo and deep skin infections may occur involving pox lesions which have been scratched. Severe, progressive, or disseminated varicella is unusual in children with normal host defenses but may be fatal in children with leukemia or other immune impairment.
Transmission/ Exposure	Person-to-person by direct contact with respiratory secretions and skin lesions; highly contagious.
Contagious Period	48 hours before onset of respiratory symptoms and 1–2 days before onset of rash until all skin lesions have crusted, usually 5–7 days. Contagiousness may be prolonged in patients with altered immunity. Susceptible persons should be considered infectious from 18–21 days following exposure. Contacting the NMDOH for specific recommendations is encouraged.
Incubation	Usually 14–16 days (up to 21 days). May be prolonged up to 28 days after administration of passive immune globulin (Vari-ZIG).
Diagnosis	Clinical diagnosis is reliable when the presentation is typical, and varicella is known to be present in the community. In vaccinated persons who develop varicella more than 42 days after vaccination, the disease is almost always mild, with fewer than 50 lesions and short duration of illness.
Management of Case	Children with varicella should not be treated with aspirin since it may increase the risk of Reye syndrome. Initial or sporadic cases of chickenpox should be confirmed by a physician. Any child with apparent chicken pox should be excluded from school until all lesions have crusted or until six days after onset of rash. Symptomatic treatment used.
Management of Contacts	Refer immune-impaired susceptible contacts (leukemia, cancer, organ transplantation, immunosuppression) to their physician immediately for passive immunization with varicella-zoster immune globulin (VZIG) after exposure. Nonimmune contacts should be quarantined and excluded from school 8–21 days after exposure. If post-exposure varicella-zoster immune globulin administered, quarantine through 28 days.
Immunization	Varicella vaccine is highly effective in prevention of chicken pox even in immune impaired individuals. It may not be effective in preventing infection if given after exposure. All children who have not had chicken pox should receive a vaccine. Immunization of susceptible exposed persons more than 5 days after exposure is not effective in preventing disease but will produce immunity in persons who are not infected.

Public Health Action	• **Must be reported** to NMDOH Epidemiology and Response Division at (505) 827-0006. • NMDOH will conduct a case investigation and coordinate follow up actions as indicated.
School Action	• Students with chicken pox should be excluded from school until all lesions have crusted or until six days after onset of rash. Students who are immune-impaired may continue to develop new vesicles for a longer period and should be excluded until all lesions have become dry and are crusted. It is not necessary for lesions to have healed completely. • Contagiousness may be prolonged in patients with altered immunity. Contact the NMDOH at 505 827-0006 for specific recommendations when dealing with altered immunity. • Identify all pregnant females and immunocompromised individuals (students and staff) who have been exposed to varicella and consult the ERD for further recommendations. • Exclude from school susceptible persons who are exposed from 8th–21st day after exposure. The NMDOH recommends contacting the ERD for further information and recommendations. • Report cases to the NMDOH (505-827-0006). • Provide prevention education. • Encourage immunization for the unimmunized.

Conjuctivitis (Pink-Eye)

Condition, Disease, Agent	**CONJUNCTIVITIS (PINK-EYE)** Adenovirus, Enterovirus, other respiratory viruses; Hemophilus influenza and other bacteria Conjunctivitis Fact Sheet: English Conjunctivitis Fact Sheet, Spanish

Clinical Description	Infectious conjunctivitis produces a variably red eye with swelling and discharge which may be watery or with mucus or pus and crusting of the eyelids. Discomfort ranges from minimal itching or a grainy sensation to substantial pain, sometimes mild photophobia (light sensitivity) or blurring of vision. In contrast, allergic conjunctivitis is usually accompanied by other signs of allergy (red conjunctiva; swollen, itching eyelids; nasal congestion; watery eye and nasal discharge; sneezing).
Transmission/ Exposure	Person-to-person by contact with infected secretions from the eye or respiratory tract either directly or through contact with contaminated objects such as shared towels or eye makeup. Viral conjunctivitis is highly contagious. Bacterial conjunctivitis is somewhat less contagious and antibiotic treatment reduces the period of communicability.
Contagious Period	Bacterial – during course of infection. Adenovirus – late in incubation period to 14 days after onset. Enterovirus – at least 4 days after onset.
Incubation	1-3 days for most bacterial infections; 4-5 days for adenovirus with average of 8 days; 12 hrs to 3 days for enterovirus
Diagnosis	Diagnosis is usually by clinical evaluation. Definitive diagnosis usually requires culture of the eye drainage.
Management of Case	Refer students with conjunctivitis for medical evaluation and treatment. An outbreak of conjunctivitis requires determination of the cause. Specific antibiotic treatment is available for conjunctivitis due to bacterial infection; symptomatic treatment is used for viral disease. Exclusion from school is usually not necessary if a child can practice frequent hand-washing. In the case of outbreaks of bacterial conjunctivitis, a patient is considered non-contagious after 24 hours of antibiotic therapy.
Management of Contacts	During outbreaks, prevention depends on scrupulous personal hygiene therapy. Outbreaks of viral conjunctivitis will usually run their course in a relatively closed community such as a school. Bacterial

	conjunctivitis may require intensive surveillance to detect new cases as early as possible. Proper disinfection of all medical and eye examining equipment is recommended. Ensure prompt hand-washing before and after eye treatment, administering eye drops, or cleansing.
Public Health Action	• Reporting to NMDOH is not required. • Contact your regional School Health Advocate and/or your regional Nurse Epidemiologist with questions or concerns as well as suggestions for control measures. • Contact the NMDOH Epidemiology and Response Division at (505) 827-0006 if the number of cases of conjunctivitis suddenly increases above what is normally observed in the school's population.
Prevention Education	Hand-washing and not touching one's eyes are the most effective defenses against eye and respiratory infections. Avoid sharing towels, eye makeup, and other items that may be contaminated. Ensure proper disposal of contaminated materials (tissues, etc.).
School Action	• Refer children with eye irritation or discharge for medical evaluation and treatment. • Report outbreaks to the NMDOH for assistance in management and recommendations. • School exclusion is usually not necessary for isolated cases but may be necessary for control of outbreaks. • Recommended to exclude children from daycare while disease is active. • Provide prevention education.

COVID-19

Condition, Disease, Agent	**COVID_19** COVID-19 is caused by a virus called SARS-CoV-2. COVID Guidance | NMDOH - Coronavirus Updates (nmhealth.org)

	Isolation and Precautions for People with COVID-19 | CDC Schools and Childcare Programs | COVID-19 | CDC
Clinical Description	COVID-19 (coronavirus disease 2019) is a disease caused by a virus named SARS-CoV-2 and was discovered in December 2019 in Wuhan, China. It is very contagious and has quickly spread around the world. It most often causes respiratory symptoms that can feel much like a cold, a flu, or pneumonia. COVID-19 may attack your lungs and respiratory system as well as other parts of your body. It is part of the coronavirus family, which include common viruses that cause a variety of diseases from head or chest colds to more severe (but rarer) diseases like severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS).
Transmission/ Exposure	The principal mode by which people are infected with SARS-CoV-2 (the virus that causes COVID-19) is through exposure to respiratory droplets and aerosols carrying infectious virus. Exposure occurs in three principal ways: (1) inhalation of very fine respiratory droplets and aerosol particles, which are released when an infected person coughs, sneezes or talks (2) deposition of respiratory droplets and particles on exposed mucous membranes in the mouth, nose, or eye by direct splashes and sprays, and (3) touching mucous membranes with hands that have been soiled either directly by virus-containing respiratory fluids or indirectly by touching surfaces with virus on them. Both vaccinated and unvaccinated people, either symptomatic or not, can spread SARS-CoV2.
Contagious Period	Covid 19 can be spread in the 48 hours prior to symptoms starting however, people are most infectious (or contagious) in the first 5 days after their symptoms start. If an individual has not had symptoms, they are considered infectious for the 2 days prior to and 5 days after the test.
Incubation	Symptoms may show up as early as 2 days after contact with an infected person or up to 14 days after exposure. On average symptoms show up within 3-5 days of contact with COVID, the Omicron variant incubation period is on average 3–4 days. Average incubation is different for different variants of COVID-19. See details for variants here: Clinical Presentation | Clinical Care Considerations | CDC
Diagnosis	The diagnosis of COVID-19 is made by direct detection of SARS-CoV-2 RNA using NAATs (most common test is RT-PCR) or by detection of viral protein using an antigen test. A positive NAAT or antigen test is generally indicative of infection and does not need to be repeated.

Management of Case	• People who have symptoms of respiratory or gastrointestinal infections, such as cough, fever, sore throat, vomiting, or diarrhea, should stay home. • Testing is recommended for people with symptoms of COVID-19 as soon as possible after symptoms begin. If a symptomatic person tests negative with an antigen test, then they should test again 24 – 48 hours later. See FDA link: At-Home COVID-19 Antigen Tests-Take Steps to Reduce Your Risk of False Negative Results: FDA Safety Communication | FDA • People who are at risk for getting very sick with COVID-19 who test positive should consult with a healthcare provider right away for possible treatment, even if their symptoms are mild. • It is recommended that the COVID positive individual isolate from others to lessen the spread of COVID. Isolate for at least 5 days after symptoms begin or testing positive. The positive individual may return to school, with a mask recommended, after 5 days if they remain fever free without fever reducing medication for a minimum of 24 hours and their symptoms are improved. • It is recommended that if fever persists longer than 5 days, the positive individual should continue to isolate and seek medical care from their primary care healthcare provider (if the individual has trouble breathing, please, seek emergency care immediately). • It is recommended that all positive individuals wear a face mask when in the presence of others for the full 10 days of infection, and if symptoms continue past the 10 days. • Thorough cleaning/disinfecting of areas or frequently touched surfaces be done after notification of the positive individual.
Management of Contacts	• Although contact tracing is no longer a requirement, COVID is still a highly contagious respiratory infection, and all reasonable measures should be taken to limit the spread within your school. • It is recommended that those who are exposed to a positive individual, test for COVID if they begin to show signs/symptoms of the disease. • It is recommended that those who are exposed to a positive individual test on day 5 after exposure or at any time they begin to have symptoms of COVID. The exposed individual may test again during the 14-day incubation period or at any time they show symptoms.
Public Health Action	• If the School Nurse or Staff perform the test for COVID, they should report positive results to NMDOH via Simple Reports.

	• Results do not need to be reported to NM PED. • You may notify your regional School Health Advocate (SHA) if you have any questions about how to proceed when you have cases in your school. Please refer to your school's enhanced COVID-Safe Practices/Safe School Plan.
Prevention Education	• Appropriate technique in hand hygiene is extremely effective in preventing the spread of infection. When and How to Wash Your Hands | Handwashing | CDC • Schools and ECE programs should teach and reinforce covering coughs and sneezes to help keep individuals from getting and spreading infectious diseases, including COVID-19. • Stay up to date with Covid-19 Vaccines. • Improving ventilation can help to decrease spread, along with choosing to do activities outside if possible. https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html • When the COVID-19 Community Level COVID-19 by County | CDC indicates are elevated, schools or ECE programs should consider adding layered prevention strategies, described below, to maintain safe, in-person learning and keep programs safely open and refer to your school's COVID Safe Practices Plan/Safe School Plan. • Follow the CDC calculator recommendations for what to do if you are exposed. What to Do If You Were Exposed to COVID-19 | CDC • Wearing a well-fitting mask or respirator consistently and correctly reduces the risk of spreading the virus that causes COVID-19. • Anyone who chooses to wear a mask or respirator should be supported in their decision to do so at any COVID-19 Community Level, including low. • Schools and ECE programs may offer diagnostic testing for students and staff with symptoms of COVID-19 or who were exposed to someone with COVID-19 in the K-12 or ECE setting, or refer them to a community testing site, healthcare provider, or to use an at-home test. • Avoiding contact with people who have suspected or confirmed Covid-19 will help prevent transmission of the virus. • CDC no longer recommends routine screening testing in K-12 schools. However, at a high COVID-19 Community Level, K-12 schools and ECE programs can consider implementing screening testing for students and staff for high-risk activities (for example, close contact sports, band, choir, theater); at key times in the year, for example before/after large events (such as prom, tournaments, group travel); and when returning from breaks (such

	as, holidays, spring break, at the beginning of the school year). In any screening testing program, testing should include both vaccinated and unvaccinated people. •
School Action	• If a school or district chooses to conduct a Point of Care rapid antigen or rapid PCR test for staff or students who present with COVID-19 like symptoms or for screening, **positive COVID-19 test results are to be reported through Simple Report.** • Ensure the positive individual has been isolated and sent home. Inform the positive individual and his/her parents/guardians (if a student), that the positive individual will need to self-isolate for 5 days from the specimen collection leading to the positive test result (or symptom start date) AND until fever-free for 24 hours without fever reducing medication AND until symptoms are improved. • Students or staff who come to school with symptoms or develop symptoms while at school should be asked to wear a well-fitting mask or respirator while in the building and be sent home and encouraged to get tested if testing is unavailable at school. Symptomatic people who cannot wear a mask should be separated from others as much as possible; children should be supervised by a designated caregiver who is wearing a well-fitting mask or respirator until they leave school grounds. • Clean high touch surfaces regularly with soap and water or with appropriate cleaning products. Sanitizing and disinfecting can further lower risk of spreading disease and kill germs remaining on surfaces. See detail guidance from CDC for further considerations with specifics on surfaces and products: When and How to Clean and Disinfect a Facility | Water, Sanitation, and Environmentally Related Hygiene | CDC. • Schools should develop mechanisms to ensure that people with COVID-19 isolate away from others and do not attend school until they have completed isolation. Once isolation has ended, the CDC recommends wearing a well-fitting mask or respirator around others through day 10. Individuals with moderate to severe covid or who are immune compromised are recommended to isolate for a full 10 days. Further CDC guidance on isolation: How To Protect Yourself and Others (cdc.gov) • In schools, people who were exposed to COVID-19 should follow recommendations to wear a well-fitting mask and get tested. School administrators can decide how to manage exposures based on the local context and benefits of preserving access to in-person learning.

	• A school may declare an outbreak if a particular school population (e.g., sports team, choir, grade level etc.) is experiencing increased COVID-19 infections above the recently observed baseline of infections. The school should then consider adding prevention strategies regardless of the COVID-19 Community Level. Schools may also consider suspending high-risk activities to control a school- or program-associated outbreak. For further strategies to employ for prevention and control of disease spread during an outbreak please contact NMDOH for assistance and refer to the following link -Operational Guidance for K-12 Schools and Early Care and Education Programs to Support Safe In-Person Learning | CDC. • When schools require that students isolate, students must be provided academic support and instruction during their days at home when they would have been at school. For example, schools may require students to do online/ remote instruction from home, or they may provide the student with instructional packets. • NMDOH COVID hotline for general questions: 1-855-600-3453
Mental Health Considerations	COVID 19 has had significant impact on the mental health of students. Since the exploration of COVID 19 many studies have been conducted to analyze the impact of COVID 19 on mental health. According to American Academy of Pediatrics Association article titled "**COVID-19 Guidance for Safe Schools and Promotion of In-Person Learning" they offer direct guidance on responding to COVID 19 "Special Considerations for School Health During the COVID-19 Pandemic -Behavioral Health/Emotional Support for Children and Adolescents"** https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools/ • Many other credible resources provide guidance and considerations as well. Each school district should refer to these when developing strategies for students and staff in response to COVID 19 or any other pandemic crisis. • If a student experiences any adverse mental health symptoms they should be referred to a school mental health professional.

Cytomegalovirus (CMV)

Condition, Disease, Agent	**CYTOMEGALOVIRUS INFECTION (CMV)** Cytomegalovirus Cytomegalovirus (CMV) and Congenital CMV Infection
Clinical Description	Mononucleosis-like syndrome with fever, malaise, and mild enlargement of lymph nodes is common in older children and adults. Infections range from sub-clinical (usual in young children) to severe systemic infection in the fetus and immune-impaired patients; manifestations may include hepatitis, pneumonia, encephalitis, and chorio-retinitis. Complications for babies born after exposure of the virus from intrauterine infection may be normal or may be growth retarded, fail to thrive, have developmental delay, or visual and hearing deficits. Severe disease in immune-impaired individuals, including AIDS, may result in blindness or respiratory failure.
Transmission/ Exposure	Contact with infected secretions (saliva, urine, genital secretions) or by blood transfusion. Infected infants or children can infect their mothers and other caregivers because of prolonged virus shedding in the urine. CMV infection can be sexually transmitted; genital contact is the mode of transmission for the average young adult who becomes infected.
Contagious Period	Weeks to many months. The virus becomes latent and can reactivate with periodic viral shedding in saliva and urine.
Incubation	3–12 weeks.
Diagnosis	Confirmation of infection requires positive culture (urine) and/or serology (IgM antibody).
Management of Case	Most treatment is symptomatic. Treatment of life-/sight-threatening infection with antiviral drugs is at least temporarily effective. Exclusion from school is not necessary.

Management of Contacts	Avoid contact with urine and saliva. Personnel who care for non-toilet-trained children or who come in contact with saliva or other body fluids, or secretions should practice careful personal hygiene, especially hand-washing. Wash contaminated toys and other objects regularly. Women who are pregnant or trying to become pregnant may wish to consult their physician to determine whether they are susceptible.
Public Health Action	• Reporting to NMDOH is not required. • Contact your regional School Health Advocate and/or your regional Nurse Epidemiologist with questions or concerns. • Contact the NMDOH Epidemiology and Response Division at (505) 827-0006 if the number of cases of CMV suddenly increases above what is normally observed in the school's population.
Prevention Education	Hand-washing is the best defense, especially after using toilet, changing diapers, assisting student with toileting, and contact with saliva.
School Action	Emphasize personal and environmental hygiene and standard precautions. School exclusion is not appropriate. Provide prevention education.

Diarrhea (Acute)

Condition, Disease, Agent	**DIARRHEA (Acute)** Viral Agents: Rotavirus, Norwalkvirus, Adenovoris. Coronavirus. Parasitic Agents: Giardia, Cryptosporidium, Entamoeba histolytica. Bacterial Agents: Salmonella, Shigella, Campylobacter, Vibrio, Yersinia, E. coli 0157-H7, Staphylococcus, Bacillus cereus, Clostridium.

	Note: See Diarrhea (Bacterial) and Norovirus pages in Foodborne Illnesses Chart
Clinical Description	Gradual to explosive onset of diarrhea with or without fever, nausea, vomiting, abdominal pain, and/or systemic toxicity.
Transmission/ Exposure	Person-to-person by fecal/oral route and by contaminated food, water, or milk. Environmental contamination may occur, especially when changing diapers.
Contagious Period	Generally, patients are contagious while symptomatic; asymptomatic carrier states may occur.
Incubation	Usually 1–3 days for viruses; 2–4 days for bacteria; often weeks for parasites.
Diagnosis	Diagnosis requires culture for bacteria and microscopic exam or antigen testing for parasites.
Management of Case	Begin hydration with increased intake of plain water or other fluids at the onset of diarrhea. Refer for medical evaluation if fever, substantial abdominal pain, inability to maintain hydration is present or stools are bloody or contain pus. Students with diarrhea should be considered for exclusion from school primarily because of hygiene issues. Those in diapers should be considered for exclusion if environmental contamination cannot be avoided. Those excluded may return to school or daycare when under appropriate treatment (if treatment is indicated) and when symptoms do not interfere with routine school activities. Any person with infectious diarrhea should avoid handling food. Those with bacterial diarrhea should avoid handling food until stool cultures are negative for the pathogen. With vibrio infections, need to be excluded until asymptomatic with formed stools.
Management of Contacts	Testing of asymptomatic contacts may be necessary to control outbreaks. Contacts should practice good personal hygiene, especially hand-washing and careful food handling.

Public Health Action	• Most pathogens that cause acute diarrhea must be reported to NMDOH Epidemiology and Response Division at (505) 827-0006 if diagnostic testing is performed. See the list of Notifiable Diseases or Conditions in New Mexico. • In cases involving an infection with a pathogen that is reported, NMDOH will conduct a case investigation and coordinate follow up actions as indicated. • Contact your regional School Health Advocate and/or your regional Nurse Epidemiologist with questions or concerns. • Contact the NMDOH Epidemiology and Response Division at (505) 827-0006 if the number of cases of diarrhea suddenly increases above what is normally observed in the school's population.
Prevention Education	Prevention requires good personal hygiene (hand-washing after using the toilet and changing diapers, and before preparing food and eating) and kitchen hygiene (separating raw and cooked food, washing utensils, counters, and cutting boards). Community prevention requires a safe water supply and uncontaminated food and milk.
School Action	• With acute diarrhea of any cause, prevent dehydration by increasing fluid intake. • Students with fever, vomiting, or diarrhea that interferes with school activity should be sent home and excluded from school until symptoms do not interfere with routine school activities. • Refer persons who have diarrhea with fever, or bloody or pus-containing stools, for medical evaluation. • Students may return to school when afebrile and diarrhea has improved to the extent that they can participate in normal activities. (See Bacterial Enteritis section for exceptions.) • Report outbreaks of diarrhea to the NMDOH immediately, especially if there is a suspicion of food or water transmission. • Frequent hand-washing should be stressed by all school staff. • Provide prevention education.

Diarrhea (Bacterial)

Condition, Disease, Agent	**DIARRHEA (Bacterial)** *Salmonella, Shigella, Campylobacter, E. coli O157-H7, Yersinia enterocolitica* Foodborne Illnesses Chart Salmonella Fact Sheet, English Salmonella Fact Sheet, Spanish Shigella Fact Sheet, English Shigella Fact Sheet, Spanish
Clinical Description	Often acute onset of diarrhea with abdominal pain/cramps, fever, nausea and vomiting, headache, and malaise. Stools may be watery or mucoid and may become bloody. Potential complications: dehydration, bacteremia and distant infection, hemolytic uremic syndrome.
Transmission/ Exposure	Person to person or animal to person by fecal-oral route and by contaminated food, milk, or water. Shigella is carried only by humans. Salmonella is carried by many animals including reptiles and may be transmitted by contaminated eggs, meat, and milk. Campylobacter is carried by poultry and domestic animals: E. coli O157 and Yersinia enterocolitica by cattle and may be transmitted by contaminated milk, meat, and water or produce contaminated with manure.
Contagious Period	Shortly before onset of symptoms, during the symptomatic illness, and sometimes after the bacterial shedding has stopped as with Salmonella.
Incubation	Depends on agent: *Campylobacter*- 2–5 days, with range of 1–10 days; *E. coli* O157-H7- usually 3–4 days, range 1–8 days; *Salmonella*- 12–36 hours, with range of 6–72 hours; - 2–4 days, with range of 1–7 days; *Yersinia enterocolitica*- usually 4–6 days, with range of 1–14 days.
Diagnosis	Stool culture to determine etiology.

Management of Case	Begin hydration with increased intake of plain water or other fluids at the onset of diarrhea. Children with other than mild to moderate watery diarrhea without fever or vomiting should be sent home. Refer for medical evaluation if fever, substantial abdominal pain, inability to maintain hydration are present, or if stools are bloody or contain pus. Some enteric infections may be treated with prescribed antibiotics. Any person with infectious diarrhea must avoid handling food. Mild diarrhea is not usually a cause for exclusion from school if the student practices good hygiene. Children in diapers or with poor hygiene should be excluded if environmental contamination cannot be avoided. Children may return to school or daycare when symptoms are subsiding and do not interfere significantly with school activities. Persons with salmonella can return when under treatment or when afebrile and diarrhea has improved. Persons with Salmonella, Shigella and E. coli O157 should not handle food until two stool cultures are negative 24 hours apart for the pathogen. Contact should not resume until diarrhea ceases and two consecutive fecal samples or rectal swabs, collected at least 24 hours apart and at least 48 hours after completion of antibiotic therapy, are negative. Symptomatic cases of shigellosis should avoid recreational water until two weeks after diarrhea stops.
Management of Contacts	Surveillance for secondary cases. Contacts should practice good personal hygiene, especially hand-washing and careful food handling.
Public Health Action	• Most pathogens that cause acute diarrhea must be reported to NMDOH Epidemiology and Response Division at (505) 827-0006 if diagnostic testing is performed. See the list of Notifiable Diseases or Conditions in New Mexico. • In cases involving an infection with a pathogen that is reported, NMDOH will conduct a case investigation and coordinate follow up actions as indicated.

	• Contact your regional School Health Advocate and/or your regional Nurse Epidemiologist with questions or concerns. • Contact the NMDOH Epidemiology and Response Division at (505) 827-0006 if the number of cases of diarrhea suddenly increases above what is normally observed in the school's population.
Prevention Education	Prevention requires good personal hygiene, especially hand-washing after using the toilet and changing diapers and before preparing food or eating; environmental hygiene including safe food handling (separating raw and cooked food, washing utensils, counters, and cutting boards).
School Action	With acute diarrhea of any cause, prevent dehydration by increasing fluid intake. Students with fever, vomiting or diarrhea should be sent home. Refer persons who have diarrhea with fever, bloody or pus containing stools for medical evaluation. For E. coli cases in daycare setting, center needs to notify parents in writing of case. Students may return to school when afebrile and diarrhea has decreased to the extent that they can participate in normal activities. Report outbreaks of diarrhea to the NMDOH, especially if there is a suspicion of food or water transmission. Frequent hand-washing should be stressed with students and staff. Provide prevention education. Avoid recreational water use by cases until symptoms resolve; for shigellosis symptoms should be resolved for two weeks before resuming recreational water contact.

Fifth Disease (Erythema Infectiosum)

Condition, Disease, Agent	**FIFTH DISEASE (ERYTHEMA INFECTIOSUM)** Human parvovirus B19 Fact Sheet: English https://www.nmhealth.org/publication/view/general/5044/ Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5045/
Clinical Description	Symptoms are a mild fever in a minimally ill child with flushed cheeks or bright red and slightly edematous "slapped" cheeks. Later in the infection, a lace-like or lattice-like rash may appear on the trunk and extremities accentuated by heat or sunlight. Many children have a history of mild gastroenteritis or upper respiratory infection a week previously. Older children and adults typically have transient arthritis lasting a few days.
Transmission/ Exposure	Person-to-person transmission by droplets or contact with respiratory secretions. Subclinical and atypical infections are very common and are contagious.
Contagious Period	Approximately one week before the rash appears; usually not contagious by the time the rash develops. Immune-impaired patients may be contagious for a prolonged period.
Incubation	4–20 days.
Diagnosis	Clinical diagnosis of typical disease occurring in outbreaks is reliable. The diagnosis can be confirmed by serology (IgM antibody) or PCR.
Management of Case	There is no specific treatment, but most cases in children resolve without intervention. School exclusion is not beneficial because transmission to other susceptible individuals will have occurred before the infection is recognized.
Management of Contacts	Parents of children with chronic anemia or immune deficiency and pregnant women should be notified of possible exposure. Pregnant women should avoid exposure due to potential fetal risk.
Public Health Action	• Reporting to NMDOH is not required.

	• Contact your regional School Health Advocate and/or your regional Nurse Epidemiologist with questions or concerns. • Contact the NMDOH Epidemiology and Response Division at (505) 827-0006 if the number of cases of Fifth Disease suddenly increases above what is normally observed in the school's population.
Prevention Education	Frequent hand-washing will minimize the risk of exposure.
School Action	• School exclusion is not helpful. • Notify parents of children with chronic anemia or immune deficiency and pregnant women when outbreaks occur. • Frequent hand-washing should be stressed for all students and school staff. • Provide prevention education.

Giardiasis, Cryptosporidiosis

Condition, Disease, Agent	**GIARDIASIS, CRYPTOSPORIDIOSIS** *Giardia lamblia, Cryptosporidium* (protozoan parasites) https://www.nmhealth.org/publication/view/general/5066/ Fact Sheet: English https://www.nmhealth.org/publication/view/general/5067/ Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5068/
Clinical Description	Diarrhea with loss of appetite, nausea, abdominal discomfort, and flatulence. Patients may have altered sense of taste or a metallic taste and frequently note headache, malaise, and similar non-specific toxic symptoms. The diarrhea is often chronic and/or recurrent and may alternate with constipation; symptoms may last for weeks or months. Individuals may carry the parasite without symptoms (asymptomatic carriers).
Transmission/ Exposure	Contamination with animal and human feces has resulted in the presence of Giardia cysts in virtually all untreated surface water accounting for cases in campers and hikers who drink untreated water. Transmission by food prepared by infected individuals or those caring for diapered infants with giardiasis has resulted in outbreaks. Person-to-person transmission by

	caretakers and children in daycare institutions has resulted in outbreaks involving substantial proportions of the children at risk. Only a small number of viable cysts (10–100) are required to establish infection, especially in persons with reduced stomach acidity. Contaminated municipal water systems have resulted in community-wide outbreaks.
Contagious Period	Variable: an untreated case may continue to excrete Giardia cysts indefinitely.
Incubation	For giardiasis, 1–4 weeks. For cryptosporidiosis, incubation period 7 days, range 1–12 days.
Diagnosis	Identification of parasites by microscopic exam or antigen test (EIA) in the stool or by antigen testing. Repeated examinations may be necessary especially if the infection is chronic.
Management of Case	Symptomatic patients should be treated with repeat treatment using same drug if initial therapy fails. Alcohol gels do not kill cryptosporidiosis. No water play or swimming for daycare cases. As long as sanitation is adequate, there is no reason to exclude a student with giardiasis or cryptosporidium after the diarrhea stops.
Management of Contacts	Symptomatic contacts should have stool examined and be excluded from handling food. Personal hygiene habits should be monitored for adequacy.
Public Health Action	• These parasitic infections **must be reported** to NMDOH Epidemiology and Response Division at (505) 827-0006. • NMDOH will conduct a case investigation and coordinate follow up actions as indicated.
Prevention Education	Avoid contact with animals with diarrhea. Animals in the school with diarrhea should be taken to the vet and isolated from children. Wash hands carefully after using the toilet or changing diapers and before preparing food and eating. Avoid ingesting untreated water. Separate diaper changing areas from play or food prep areas.
School Action	• Refer suspected cases for diagnosis and treatment. • Report outbreaks to the NMDOH.

	• School exclusion is usually not necessary unless the student is unable to maintain continence of stool. • Exclude symptomatic contacts from handling food. • Classroom animals with diarrhea should be isolated. • Provide prevention education. • For day care setting, center should notify parents in writing of a case in the daycare.

Haemophilus influenzae Invasive Disease

Condition, Disease, Agent	***Haemophilus influenzae* Invasive Disease** https://www.nmhealth.org/publication/view/general/5069/ Fact Sheet: English https://www.nmhealth.org/publication/view/general/5070/ Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5071/
Clinical Description	*Haemophilus influenzae* is classified into six capsular types (a though f) and nonencapsulated (nontypable) strains. Haemophilus influenzae are gram-negative coccobacilli that cause a broad range of infections. The organism is transmitted person to person by respiratory droplets. The most common manifestations of invasive disease are bacteremia, meningitis, pneumonia epiglottitis, septic arthritis, or other musculoskeletal disease. Signs and symptoms may include fever, headache, meningismus, cough, respiratory distress, bone or joint pain, or general illness. Non-encapsulated or nontypeable strains of *H. influenzae* usually cause noninvasive infections including otitis media, sinusitis, conjunctivitis, pneumonia, and bronchitis.
Transmission/ Exposure	The organism resides in the human upper respiratory tract. Person-to-person transmission occurs through inhalation of respiratory droplets or through direct contact with respiratory tract secretions. Pharyngeal colonization is common, especially with non-type b strains. Widespread vaccination with Hib vaccine has markedly reduced colonization rates of type b. Colonization rates increase following recent exposure in closed populations (such as family or childcare contacts of a person with disease). Colonization can persist for months.

Contagious Period	Period of communicability is undefined as the organism can be transmitted as long as it is present in the nasopharynx. For patients with invasive Hib disease, the patient is considered noninfectious 24 hours after initiation of appropriate antimicrobial therapy.
Incubation	Incubation period is unknown.
Diagnosis	*H. influenzae* can be cultured from blood, cerebrospinal fluid (CSF), synovial fluid, sputum, and pleural fluid. A gram stain of infected body fluid can demonstrate the organism and allow a presumptive diagnosis to be made. Because the type b capsular antigen can be detected in body fluids, including urine, blood, and CSF of patients, clinicians often request a rapid antigen detection test for diagnosis of Hib disease.
Management of Case	Patients with invasive *H. influenzae* must receive antimicrobial therapy. The choice of specific therapy should consider local antibiotic susceptibility patterns. Treatment decisions are made by the patient's health care provider, and consultation with infectious disease specialists can be beneficial in treating invasive infections.
Management of Contacts	For close contacts of patients with invasive Hib Type b disease, prophylaxis with rifampin is indicated. Consultation with the Epidemiology Response Division of the NMDOH, (505) 827-0005, is recommended for specifics on who needs prophylactic treatment
Public Health Action	• **Must be reported** to NMDOH Epidemiology and Response Division at (505) 827-0006. • NMDOH will conduct a case investigation and coordinate follow up actions as indicated.
Prevention Education	Age-appropriate vaccination is the primary way to prevent invasive Hib disease. Infants routinely begin the primary immunization series at age 2 months with subsequent vaccines at ages 4 and 6 months. A booster dose is given at ages 12–15 months. A schedule is available for unvaccinated children up to 72 months (6 years) of age. Hib vaccine is not typically given after age 6 years.

School Action	• Refer suspected cases for diagnosis and treatment. • Report suspected cases to the NMDOH. • Ensure appropriate immunization of students, especially for those in day care or pre-kindergarten programs. • Encourage good hand-washing in school. • Encourage staff and students to cover their mouth and noses when coughing or sneezing and to wash their hands afterwards.

Hand, Foot, and Mouth Syndrome

Condition, Disease, Agent	**HAND, FOOT AND MOUTH DISEASE (HFMD)** *Groups A and B Coxsackieviruses, Enteroviruses* HFMD Fact Sheet, English HFMD Fact Sheet, Spanish
Clinical Description	This illness is characterized by fever and flu-like illness and a non-specific rash and tiny blisters in mouth and on fingers, palms of hands, buttocks, and soles of feet. The rash may be raised or flat red spots. Mouth discomfort may make it difficult to eat or drink.
Transmission/ Exposure	Person to person contact, respiratory droplets (nasal discharge, saliva) or blister fluid contact with contaminated surfaces, and fecal-oral route.
Contagious Period	Respiratory route – less than a week after symptoms appear; fecal-oral route – viral shedding in feces can occur for several weeks after symptoms appear.
Incubation	Typically, 3–7 days.
Diagnosis	Usually clinical diagnosis is sufficient; however, coxsackievirus can be identified by culture and other enteroviruses by PCR
Management of Case	Ill students who do not feel well enough to perform usual activities at school should stay home. Otherwise, children may continue to attend school unless they have fever or uncontrolled drooling/diarrhea. Hydration should be encouraged despite discomfort in the mouth.

	School staff should be alerted to watch for symptoms in other students. Hand-washing and appropriate disposal of contaminated articles are important in disease control in the school setting, as well as limiting activities where shared equipment/toys and/or in pools during infectious period. Refer suspected cases for diagnosis and supportive treatment as appropriate.
Management of Contacts	Encouraging good hygiene is the most effective management along with preventive education. Symptomatic contacts should not be handling food for consumption by others.
Public Health Action	• Reporting to NMDOH is not required. • Contact your regional School Health Advocate and/or your regional Nurse Epidemiologist with questions or concerns. • Contact the NMDOH Epidemiology and Response Division at (505) 827-0006 if the number of cases of HFMD suddenly increases above what is normally observed in the school's population.
Prevention Education	Prevention education should include covering mouth when sneezing and coughing, proper disposal of contaminated articles, good hand-washing technique, adequate fluid intake, and good diapering technique. limiting activities where shared equipment/toys and/or in pools during infectious period.
School Action	Refer suspected cases for diagnosis and supportive treatment as appropriate. Reach out to your regional School Health Advocate with questions or concerns. For questions concerning outbreak management call the NMDOH Epidemiology and Response Department (505-827-0006). School exclusion is not necessary unless the student has fever, has uncontrolled drooling with mouth sores, or is unable to maintain continence of stool. Exclude symptomatic contacts and cases from handling food. Encourage adequate hydration.

	Provide prevention education. Clean and disinfect frequently touched surfaces and shared items.

Hantavirus Pulmonary Syndrome (HPS)

Condition, Disease, Agent	**HANTAVIRUS PULMONARY SYNDROME (HPS)** RNA virus of *Bunyaviridae family* https://www.nmhealth.org/publication/view/general/5072/ Fact Sheet: English https://www.nmhealth.org/publication/view/general/5073/ Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5074/
Clinical Description	The prodromal illness consists of fever and myalgias with variable respiratory symptoms, abdominal pain, vomiting, or diarrhea followed by progressive cough, shortness of breath, and dizziness which reflect cardio-respiratory insufficiency. May progress to respiratory failure or shock.
Transmission/ Exposure	Contact with aerosolized rodent feces and urine (mainly deer mice) or saliva is the presumed mode of transmission. Indoor exposures in closed, poorly ventilated homes, vehicles, and outbuildings with visible rodent infestations are especially suspect.
Contagious Period	No person-to-person infections have been documented in North America.
Incubation	Approximately 2 weeks with range of 1–6 weeks.
Diagnosis	Diagnosis is made by demonstration of specific IgM antibodies in specialized laboratory testing.
Management of Case	There is no specific treatment; supportive care includes respiratory intensive management of pulmonary edema, severe hypoxemia, and hypotension needs occur within the first 48 hours. Patients should be rapidly transferred to a tertiary care facility. Bed rest and early diagnosis are critical in disease outcome. School exclusion is not a consideration.

Management of Contacts	None.
Public Health Action	• **Must be reported** to NMDOH Epidemiology and Response Division at (505) 827-0006. • NMDOH will conduct a case investigation and coordinate follow up actions as indicated.
Prevention Education	Exterminate rodents in home and avoid contact with rodent feces and urine. Store human and animal food in rodent-proof containers and disinfect rodent-contaminated areas by spraying a disinfectant such as 10% bleach solution prior to cleaning. Limit possible rodent nesting sites. Seal holes and other possible rodent entrances (mice can squeeze through holes the size of a dime). Do not use brooms and vacuums to clean rodent infested areas. Avoid inhalation of dust in infested areas by wearing approved respirators when cleaning these areas.
School Action	• School exclusion is not appropriate. • Provide prevention education.

Hepatitis A

Condition, Disease, Agent	Hepatitis A virus https://www.nmhealth.org/publication/view/general/5075/ Fact Sheet: English Fact Sheet: Spanish
Clinical Description	Symptoms include fever, nausea, vomiting, loss of appetite, or distaste for certain foods followed in 3–10 days by dark brown urine, pale feces, and jaundice (yellow discoloration of eyes, skin and mucous membranes). About 70% of hepatitis A infections in young children are without symptoms or are a gastroenteritis-like illness without jaundice, compared to 50% of infections in school-age children and 20% in adults.

Transmission/ Exposure	Person-to-person by fecal-oral mechanism both direct and indirect. Contaminated food or water may lead to outbreaks. Secondary cases occur in families and other close groups where people share food and drinks. Persons at high risk of transmission in schools are food handlers and staff who do diapering and toileting. Good hand-washing is key to preventing transmission.
Contagious Period	Latter half of incubation period through first week after onset of jaundice.
Incubation	Usually 5–50 days with an average of 30 days.
Diagnosis	Exam shows jaundice with liver enlargement and tenderness as with other types of hepatitis. Laboratory testing results in elevated enzymes (SGPT/ALT), and elevated bilirubin reveals mild to severe liver injury. Hepatitis A IgM antibody is usually present at the onset of jaundice.
Management of Case	Refer students with jaundice for medical evaluation. Students in the active phase of illness may be too sick to attend school. Those with a clinical diagnosis of Hepatitis A should be excluded until one week after onset of jaundice or in absence of jaundice for 14 days after appearance of symptoms.
Management of Contacts	Close contacts should be given immune globulin (IG) within two weeks after exposure. Older children are less likely to spread hepatitis A within the classroom. If Hepatitis A transmission occurs within a school, students and staff in the same classroom may be given IG prophylaxis. Hepatitis A vaccine used for post-exposure prevention for ages 12 months to 40 years; for older adults IG is favored.
Public Health Action	• **Must be reported** to NMDOH Epidemiology and Response Division at (505) 827-0006. • NMDOH will conduct a case investigation and coordinate follow up actions as indicated.
Immunization	One dose of Hepatitis A vaccine is required for childcare enrollment at 16 months and older in New Mexico and is recommended for all children in high incidence communities. It can be given to children 12 months of age or

	older. Hepatitis A vaccine may also be recommended to school populations when one or more students have acute Hepatitis A disease.
Prevention Education	Hand-washing after using the toilet, changing diapers, and assisting children with toileting, and before handling food and eating is the most important preventive measure. Keeping toilet and food preparation areas clean and will minimize risk of disease transmission. Use standard precautions for bloodborne pathogens.
School Action	• Refer jaundiced students for medical evaluation. • Report suspected cases to the NMDOH (505) 827-0006. • Consider exclusion of Hepatitis A confirmed cases until one week after onset of jaundice. • Encourage use of IG and Hepatitis A vaccine as recommended by the NMDOH. Prophylaxis not recommended after exceeding two weeks of exposure. • Prophylaxis not necessary with a single case unless behavior defined as "close contact with a confirmed case is documented." • Exclude confirmed cases from food handling. • Provide prevention education. • Use standard precautions for bloodborne pathogens.

Hepatitis B and C (Acute)

Condition, Disease, Agent	**HEPATITIS B and C (Acute)** Hepatitis B virus (HBV) and hepatitis C virus (HCV) Hepatitis B Fact Sheet, English Hepatitis B Fact Sheet, Spanish Hepatitis C Fact Sheet, English Hepatitis C Fact Sheet, Spanish
Clinical Description	Symptoms may include anorexia, nausea, malaise, jaundice, arthritis, and skin rashes. Complications may include liver failure, chronic hepatitis, and eventual cirrhosis or liver cancer.
Transmission/ Exposure	Usually by direct and indirect contact with infected blood or body fluids or objects contaminated with blood or genital secretions. Contact may be parenteral (injection drug use, accidental needle

	stick, or transfusion) or by sexual contact; HB can potentially be transmitted by close family contact (e.g., sharing toothbrushes, razors, tweezers, scissors and/or nail-clippers).
Contagious Period	Anytime virus is present in blood, secretions and body fluids containing blood, in genital secretions (semen, vaginal fluid) and for many weeks before onset of symptoms. Chronic carrier states for both viruses are common.
Incubation	HBV is an average of 90 days with a range of 45–160 days. HCV is usually 36–63 days with a range of 14 days to 6 months.
Diagnosis	Serology for acute hepatitis B usually shows hepatitis B surface antigen and IgM antibody to core antigen (IgM anti-HBc). Serology for hepatitis C is a test for total antibody (anti-HCV).
Management of Case	Refer students with suspicion of hepatitis for medical evaluation. School exclusion is unnecessary; however, the student may be too ill to participate in school activities.
Management of Contacts	Contacts of Hepatitis B and C should be evaluated for risk of infection. Needle sharing, sexual contact, or close family contact with an infected individual is indication for serologic testing and immunization for Hepatitis B.
Public Health Action	• **Must be reported** to NMDOH Epidemiology and Response Division at (505) 827-0006. • NMDOH will conduct a case investigation and coordinate follow up actions as indicated.
Immunization	Infants should receive hepatitis B vaccine along with other routine immunizations. As of 2002, Hep B vaccine is required for school entry in NM. Any unvaccinated person at increased risk of hepatitis B infection should receive vaccine.
Prevention Education	Avoid contact with blood and body fluids; avoid injections, tattoos, etc. with unsterile equipment. Practice safe sex including use of latex

	condoms. Persons who inject illicit substances (including steroids) should be encouraged to stop or to obtain sterile needles and equipment from local PHO under the Harm Reduction Program (505) 476-3136. Use standard precautions for blood borne pathogens.
School Action	• Refer children with jaundice or other suspicion of hepatitis for medical evaluation. • Monitor immunization status of students. • Report confirmed cases to the NMDOH. School exclusion is not necessary. • Observe standard precautions for bloodborne pathogens. Monitor students who are chronic carriers of HBV for behavior that may place others at risk (biting for example). • School staff identified at high risk for exposure to HBV in the school districts blood borne pathogen exposure plan should receive Hepatitis B vaccine. • Provide prevention education. • Refer sexual contacts of an infected person to the NMDOH for testing and appropriate immunization. • Respect the right to confidentiality of infected persons.

Herpes Simplex, Non-Genital Infections ("Cold Sores")

Condition, Disease, Agent	**HERPES SIMPLEX, NON-GENITAL INFECTIONS ("Cold Sores")** Herpes simplex virus (HSV), type 1
Clinical Description	Symptoms include vesicles (small blisters) on the skin and/or mucus membranes that rupture quickly leaving painful ulcers and dry crusts (on skin), satellite vesicles form for several days with primary infection. There may be fever and malaise lasting five or more days. Recurrent infections are common and usually occur in the same area as the primary lesion. "Cold sores" and "fever blisters" may be initiated by trauma, emotional stress, menstruation, illness, or fever. Recurrent lesions are usually smaller and heal more quickly. Herpes gladiatorum is a herpetic skin infection (usually HSV-1) usually of the trunk or extremities of wrestlers and other athletes probably resulting from salivary inoculation of minor skin abrasions. HSV-1 may spread

	to the eye and cause inflammation and ulceration of the cornea. Patients with eczema (rarely other types of dermatitis) may develop widespread herpetic infection of their skin lesions.
Transmission/ Exposure	Contact with oral secretions of infected persons with or without symptoms; contact with open lesions from which eyes or genitals may become infected.
Contagious Period	7–50 days following onset of primary infection and for typically 3–4 days after onset of a recurrent episode. Patients may have asymptomatic shedding of the virus and may be capable of spreading the infection when they have no symptoms.
Incubation	2–12 days for primary infection.
Diagnosis	Diagnosis is made on clinical evaluation of the lesions.
Management of Case	Refer for medical evaluation for apparent primary infection or for frequent or severe recurrences. Oral (or in severe cases, intravenous) acyclovir is effective in shortening the duration of primary episode and reduces viral shedding. Those with frequent recurrences may be able to suppress them with continuous oral acyclovir, valacyclovir, or famciclovir. Topical Carmex and camphor products can be used to relieve symptoms.
Management of Contacts	Protect students with eczema or severe immune deficiency, and newborns, from exposure to persons with active herpes infections. Covering lesions with clothing or a loose dressing will curtail most transmission, since hand contact with lesions will be minimized. Avoid contact with lesions such as kissing or sharing drinks and utensils.
Public Health Action	Not a reportable condition.
School Action	• School exclusion is not necessary. Children with primary HSV gingivostomatitis who can’t control oral secretions should be excluded from daycare or school until symptoms resolve.

	• Infected students should be taught to frequently disinfect surfaces and objects routinely contaminated with oral secretions. • Persons in physical contact with students who have active lesions and who cannot control their oral secretions should wash their hands frequently and use standard precautions for bloodborne pathogens. • Exclude athletes in contact sports from competition while they have open lesions that cannot be covered. • Disinfect sports equipment (especially mats) after practice and competition. • Provide prevention education.

Impetigo

Condition, Disease, Agent	**IMPETIGO** Group A *Streptococci* (GAS), *Staphylococcus aureus* Impetigo Fact Sheet, English Impetigo Fact Sheet, Spanish
Clinical Description	Flat yellow crusty or weeping lesions seen commonly on face and arms that are usually superficial at first proceeding through vesicular, pustular, and encrusted stages. Impetigo can occur as a complication of abrasions, insect bites, and chicken pox. Outbreaks can occur in populations with much skin-to-skin contact and a high rate of GAS carriage.
Transmission/ Exposure	Direct person-to-person contact of colonized skin or lesion to skin transmission most common; respiratory droplets of asymptomatic.
Contagious Period	Variable, at least while lesions are actively weeping and crusting, and carrier state exists; not contagious 24 hours after initiation of effective antibiotic.
Incubation	Streptococcal – 7 to 10 days; staphylococcal – 4 to 10 days

Diagnosis	Usually clinical diagnosis. Culture and sensitivity of the lesion if diagnosis is uncertain.
Management of Case	Local skin infection is managed by cleaning the area and applying appropriate (prescription) topical antimicrobial ointment. Systemic antimicrobial therapy is usually not indicated unless an infection spreads significantly or there is impetigo in multiple family members or school attendees. A student with this disease should not return to school until 24 hours after antibiotic treatment has been started; large weeping lesions should be covered by clothing or a loose dressing.
Management of Contacts	Careful surveillance of contacts and persons living in close contact (home and school). Improved personal hygiene will minimize the risk of infection of minor wounds. Use standard precautions for bloodborne pathogens.
Public Health Action	Outbreaks of impetigo and complications of streptococcal infection should be reported to the NMDOH at (505) 827-0006.
School Action	• Refer suspected cases for medical evaluation and treatment. • Exclude infected students from school until after 24 hours of antibiotic treatment is completed. • Stress good personal hygiene and avoidance of contact with lesions by unaffected. Monitor students with lesions and cover with clothing or a loose dressing as appropriate. • Provide prevention education. • Use standard precautions for bloodborne pathogens. • Properly dispose of wound dressings.

Influenza

Condition, Disease, Agent	**INFLUENZA VIRUS (TYPES A AND B)** https://www.nmhealth.org/publication/view/general/5084/ Influenza Fact Sheet, English Influenza Fact Sheet, Spanish

Clinical Description	Acute respiratory infection ("flu") is characterized by sudden onset of fever, chills, headache, malaise, myalgias, and respiratory symptoms including sore/scratchy throat, nasal congestion, and cough. Abdominal pain, vomiting, and diarrhea are not uncommon in children infected with influenza. Infections may be subclinical or very mild. Bacterial superinfections are relatively common, including bronchitis, pneumonia, otitis media, and sinusitis.
Transmission/ Exposure	Direct and indirect contact with respiratory secretions either by large droplets through sneezing and coughing or contact with contaminated surfaces or objects via hand inoculation of the eye and nose. May be transmitted via airborne route also.
Contagious Period	One day prior to onset of symptoms and up to 5 days after onset. Young children can be contagious from several days prior to symptom onset and up to 10 days after.
Incubation	1-4 days.
Diagnosis	Clinical diagnosis is usually reliable when symptoms are typical, and influenza is circulating in the community. Diagnosis can be confirmed by PCR tests or viral antigen point of care tests. Cultures for influenza take more time for results but can identify the influenza type which is important for surveillance.
Management of Case	Children and adults with clinical influenza should be sent home until fever subsides. Fluids are important to maintain hydration. Bed rest and analgesics (other than aspirin) may help symptomatically. The influenza cough may persist for weeks and may limit activity, especially for those with asthma. Students should not return to school until they are afebrile for 24 hours without antipyretics and systemic symptoms have subsided (usually 3–7 days).
Management of Contacts	All individuals 6 months of age and older should receive influenza vaccine annually. Encourage good hand hygiene and appropriate disposal of

	contaminated articles. Emphasis should be placed on obtaining flu vaccine for individuals at risk for influenza complications and those who come into contact with persons at increased risk.
Immunization	Influenza vaccine changes each year, so it should be repeated annually.
Public Health Action	Notify the NMDOH at (505) 827-0006 when outbreaks of respiratory disease appear in a school.
School Action	• Exclude students and staff with clinical influenza until afebrile (less than 100.4°F) for 24 hours without antipyretics and symptoms have subsided. • Report suspected outbreaks of respiratory disease to the NMDOH. • Emphasize hand-washing and respiratory droplet precautions in prevention education. • Offer influenza vaccination to students and staff through school health programs. • Consider student absenteeism and staff availability when making decisions regarding school closure when outbreaks occur. • Provide prevention education. • In the case of a novel influenza virus with pandemic activity, updated guidance will be provided by the NMDOH.

Meningitis (Bacterial)

Condition, Disease, Agent	**MENINGITIS (BACTERIAL)** *Neisseria meningitidis* (meningococcus), *Streptococcus pneumoniae* https://www.nmhealth.org/publication/view/general/5096/ Meningococcal Fact Sheet, English Meningococcal Fact Sheet, Spanish
Clinical Description	Invasive bacterial disease is manifested by fever, chills, malaise, rash that may be macular, maculopapular, or petechial, stiff neck, headache, vomiting, and possibly stupor or loss of consciousness. Potential complications include shock, respiratory failure, seizures, coma, and death. Neurologic complications of meningitis include deafness, seizure disorders, acquired

	learning disabilities or developmental retardation, and paralysis (cerebral palsy).
Transmission/ Exposure	Direct person-to-person transmission through droplet spread or contact with respiratory secretions; may be carried in the throat or nasopharynx by asymptomatic individuals.
Contagious Period	Healthy carriers are potentially infectious. Patients with bacterial meningitis once started on appropriate antibiotic therapy are generally non-contagious within 24 hours.
Incubation	Usually 3–4 days with a range of 2–10 days.
Diagnosis	Examination of the spinal fluid and culture of blood and spinal fluid are required to confirm the clinical diagnosis and guide therapy.
Management of Case	Bacterial meningitis is a life-threatening illness requiring immediate hospitalization and antibiotic treatment and respiratory isolation for 24 hours after initiating therapy. The infected student may return to school at the advice of a medical provider with any limitations specified by him/her.
Management of Contacts	All individuals 6 months of age and older should receive influenza vaccine annually. Encourage good hand hygiene and appropriate disposal of contaminated articles. Emphasis should be placed on obtaining flu vaccine for individuals at risk for influenza complications and those who come into contact with persons at increased risk.
Immunization	Influenza vaccine changes each year, so it should be repeated annually.
Public Health Action	Notify the NMDOH at (505) 827-0006 when outbreaks of respiratory disease appear in a school.
School Action	• Exclude students and staff with clinical influenza until afebrile (less than 100.4°F) for 24 hours without antipyretics and symptoms have subsided. • Report suspected outbreaks of respiratory disease to the NMDOH.

	• Emphasize hand-washing and respiratory droplet precautions in prevention education. • Offer influenza vaccination to students and staff through school health programs. • Consider student absenteeism and staff availability when making decisions regarding school closure when outbreaks occur. • Provide prevention education. • In the case of a novel influenza virus with pandemic activity, updated guidance will be provided by the NMDOH.

Meningitis (Viral or Aseptic)

Conditions, Disease, Agent	**MENINGITIS (VIRAL or ASEPTIC)** *Enteroviruses (ECHO and Coxsackie), other viruses* CDC information: https://www.cdc.gov/meningitis/viral.html
Clinical Description	Symptoms include fever, headache, stiff neck, back pain, vomiting, malaise, drowsiness, altered consciousness, prostration, and possibly rash. Although enteroviral infections can occur year-round, they are most common in summer and early fall. Seizures, coma, and neurologic complications can occur. Children with suspected meningitis represent a medical emergency and should be immediately evaluated by a health-care provider and excluded from childcare until the cause of the meningitis is identified.
Transmission, Exposure	Direct person-to-person infected secretions from throat or nose; fecal-oral contamination for many enteroviruses.
Contagious Period	Weeks to months depending on causative agent; most infectious during stage of illness.
Incubation	Variable depending on virus, 3–6 days for enteroviruses.
Diagnosis	Examination of spinal fluid and spinal fluid culture can help to confirm clinical diagnosis.
Management of Case	There is no specific treatment. Supportive treatment is provided as indicated by the specific clinical indications. When the infected student has recovered, he/she

	may return to school with limitations according to a medical provider's recommendations.
Management of Contacts	Other cases of enteroviral infection are likely to occur in the same school or other group setting, but it is not likely that there will be other cases of meningitis or other serious illness. Contacts with symptoms suggestive of meningitis should be referred for medical evaluation immediately. Good hand-washing practices by all should be enforced at school.
Immunization	None available.
Public Health Action	Not required.
School Action	• Refer suspected students for medical evaluation. • School exclusion is not necessary unless prescribed by a medical provider. • Provide prevention education to include good hand-washing practices.

MRSA (Methicillin-Resistant Staphylococcus Aureus)

Condition, Disease, Agent	**MRSA (METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS)** *Staphylococcus aureus* bacteria MRSA Fact Sheet, English MRSA Fact Sheet, Spanish
Clinical Description	MRSA is a type of Staphylococcus aureus that is resistant to some antibiotics including methicillin. "Staph" aureus is found on the skin of many people but does not cause infection or illness until these bacteria get into a cut, scrape, or other break in the skin. Many people carry staph bacteria on their skin but have no symptoms of disease. Infections can look like a pimple, rash, boil, or open wound.

Transmission, Exposure	Direct skin-to-skin contact such as holding hands or engaging in contact sports with hands being most common instrument of transmission; indirect through contact with items touched or used by infected person or staph carrier such as razors, towels, athletic equipment, clothing
Contagious Period	As long as bacteria is carried on the skin.
Incubation	Variable and indefinite.
Diagnosis	Isolation of S. aureus from culture is definitive.
Management of Case	Early treatment can help prevent MRSA infection from worsening. All skin lesions should be covered with clean, dry pads. The infected student may need to avoid certain activities such as contact sports or gym activities so that lesion dressing remains intact, and the body can heal. Gloving, hand-washing, and proper disposal of contaminated materials is essential in care delivery. Prescribed antibiotics should be taken as directed; provider should be contacted if improvement is not evident in a few days. Students or staff infected or with suspect infection need **not** be excluded from school.
Management of Contacts	Good hand-washing practices and observation are important for known contacts. There is no vaccine or preventative medication available for MRSA exposure.
Immunization	None available.
Public Health Action	Contact NMDOH (505-827-0006) if more than one case of MRSA is diagnosed or suspected in the same school.
Prevention Education	Wash hands frequently with soap and water. Keep cuts and scrapes clean with soap and water and covered with dry pads. Do not pick, touch, or scratch skin lesions or touch another's sores/lesions. Avoid skin contact and sharing personal items with anyone suspected of having MRSA. To prevent antibiotic-resistance from occurring, do not request antibiotics for colds or other viruses and take all antibiotics prescribed even if symptoms disappear before finishing the medication.
School Action	• Do not exclude students or staff with MRSA infections. • Alert parents of school cases only after collaboration with the NMDOH.

	• Encourage frequent hand-washing and proper coverage of all skin wounds. • Ensure access to sinks, soap, and clean towels and/or alcohol-based sanitizers. • Infected students may need to avoid gym activities and contact sports to prevent wound dressings from coming off. • Clean athletic equipment daily if used by more than one individual. • Follow standard precautions when providing care for infected student. • Report **more than one case** to NMDOH (505-827-0006).

Molluscum Contagiosum

Condition, Disease, Agent	**MOLLUSCUM CONTAGIOSUM** **Molluscum Contagiosum/Poxvirus/CDC**
Clinical Description	Viral benign, mild superficial skin infection. Typically, the infection spontaneously resolves within 6-12 months, but may be present as long as 4 years. Characterized by flesh-colored to translucent dome-shaped bumps, the center of the bump is often indented. Lesions commonly occur on the trunk, face, and extremities in clusters, not typically covering the entire body. The lesions can be itchy. It is most common in children 1-10 years of age. Children with a weakened immune system or other skin conditions may be more symptomatic than children with normal defenses.
Transmission, Exposure	Person-to-person by direct contact with skin lesions and contaminated fomites. The virus may spread by contact exposure with objects such as towels, clothes, and surfaces. Scratching lesions may spread rash to other parts of the body. It cannot spread through coughing or sneezing.
Contagious Period	When lesions are present, the virus can spread to others. Once the lesions are gone, the virus is gone. Contacting the NMDOH for specific recommendations is encouraged.

Condition, Disease, Agent	**MOLLUSCUM CONTAGIOSUM** **Molluscum Contagiosum/Poxvirus/CDC**
Incubation	Typically, 2-7 weeks or as long as 6 months.
Diagnosis	Clinical diagnosis is reliable when the presentation is characterized by typical dome-shaped indented lesions. Serologic testing is not available.
Management of Case	In most cases, no treatment is needed. Management of itching helps to prevent spread and secondary infection due to open skin. It is recommended that children with genital lesions be seen by a provider and screened for sexually transmitted infections. No quarantine or isolation necessary. Under direction of Clinician, topical treatments or physical destruction of lesions can be performed. Refer immune-impaired susceptible contacts to their provider immediately for management.
Management of Contacts	No quarantine or isolation necessary.
Immunization/Prevention	Good hygiene habits prevent the spread of infection. Handwashing being the best prevention strategy. Touching and scratching lesions can spread the virus and should be avoided. Cover lesions when possible and avoid sharing gear if it cannot be covered.
Public Health Action	No control measures recommended for isolated cases. You may contact NMDOH SHAs for questions.
School Action	• A student with Molluscum Contagiosum can attend school or day care without limitations. • Maintain confidentiality and consider mental health implications of long-term skin abnormalities. • Provide prevention education. • Contact the NMDOH at 505 827-0006 for specific recommendations when dealing with altered immunity.

Condition, Disease, Agent	**MOLLUSCUM CONTAGIOSUM** **Molluscum Contagiosum/Poxvirus/CDC**
Writers Editors/Reviewers	Vicki Casias, BSN, RN School Health Advocate, NW Region & Kathryn Willits, RN Epidemiology Nurse, NW Region Maricelda Pisana, Kate LaRose, Crista Pierce, Dr. Marciniak, Dr. Bustos, Dr. Ross, Dr. Novak, Jim Farmer

Mononucleosis (Infectious Mononucleosis, Mono)

Condition, Disease, Agent	**MONONUCLEOSIS (INFECTIOUS MONONUCLEOSIS, MONO)** most common virus is Epstein-Barr virus (EBV) CDC information: https://www.cdc.gov/epstein-barr/about-mono.html
Clinical Description	Persons with "mono" usually have fever, sore throat, cervical adenopathy, and fatigue. Less commonly, patients have splenomegaly (enlarged spleen). Fatigue may be severe and prolonged. Symptoms may return after a period of convalescence. Adolescents and young adults tend to have more typical disease.
Transmission, Exposure	EBV is the most common cause of infectious mononucleosis, but other viruses can cause this disease. Typically, these viruses spread most commonly through bodily fluids, especially saliva (kissing or sharing drinks, toothbrushes, etc). However, these viruses can also spread through blood and semen during sexual contact, blood transfusions, and organ transplantations.
Contagious Period	Viral shedding begins before onset of symptoms; periodic shedding occurs even after complete recovery for as long as a year or more and is probably the source of most new infections.
Incubation	4–6 weeks.
Diagnosis	Health-care providers typically diagnose infectious mononucleosis based on symptoms. Lab tests may show an increase in lymphocytes with many "atypical

	lymphocytes." Serologic tests are usually positive by the second week of illness.
Management of Case	Because of a small risk of rupture of the enlarged spleen, infected students should be excluded from contact sports until the spleen has returned to normal size. There is no specific treatment for "mono." Infected students who are well enough to attend school should not be excluded.
Management of Contacts	Because the virus is present in saliva, hand-washing, and washing objects contaminated with saliva should reduce transmission from person to person. Discourage engaging in activities involving exchange of saliva with infected individuals.
Immunization	None available.
Public Health Action	EBV infections are not reportable.
School Action	• Refer children with suspected infectious mononucleosis for medical evaluation. • Infected students who are well enough to attend school should not be excluded. • Students with enlarged spleen should avoid contact sports until medical clearance is received. Students typically can return to contact sports four weeks from start of symptoms but may need to stay out longer if symptoms of fatigue persist. • Provide prevention education.

Mumps

Condition, Disease, Agent	**MUMPS** Mumps virus, RNA virus https://www.nmhealth.org/publication/view/general/5108/ Mumps Fact Sheet, English

	Mumps Fact Sheet, Spanish
Clinical Description	Mumps is an acute viral infection characterized by fever and enlargement of the salivary glands. Pancreatitis, orchitis in males, oophoritis in females, and encephalitis may occur, but rarely. Complications are more common in adults.
Transmission, Exposure	Direct airborne transmission or respiratory droplets or direct contact with saliva of infected person.
Contagious Period	6–7 days before until 9 days after swelling begins.
Incubation	16–18 days after exposure with a range of 12–26 days.
Diagnosis	Clinical diagnosis of symptomatic mumps is reliable in outbreaks; however, isolated cases of salivary gland swelling may be caused by other viruses, blockage of a salivary duct, or bacterial infection. Virus isolation and serology including detection of IgM antibodies are recommended. Confirmation of the disease is important before extensive surveillance or immunization is undertaken.
Management of Case	Refer students with suspect mumps for medical evaluation. There is no specific treatment; most school-age children are only mildly ill. School exclusion should be for 5 days after onset of swelling.
Management of Contacts	Contacts of mumps cases who have not had two doses of mumps vaccine should be immunized preferably with MMR vaccine. Contacts with no prior history of mumps illness or immunization should be excluded from school from the 12^{th} through 25^{th} day after exposure and should be considered for mumps vaccine. Testing adults to determine susceptibility should be considered before vaccination with MMR since a majority of adults without a history of mumps will be immune. because of subclinical or unrecognized infection. Mumps in adults is more likely to be severe with systemic involvement.
Immunization	All students are required to have two doses of MMR vaccine before school entry.
Public Health Action	Report cases and suspect cases to the NMDOH at (505) 827-0006.

School Action	• Refer students with enlarged salivary glands for medical evaluation. • Exclude students with confirmed mumps for 5 days following onset of swelling. • Exclude susceptible contacts from day 12 through day 25 after exposure. Excluded students can be readmitted immediately after immunization. • Exclude students who are exempted from mumps immunization until at least 26 days after onset of swelling in the last contact case of exposure. • Provide prevention education.

Norovirus

Condition, Disease, Agent	**NOROVIRUS** Norovirus, RNA virus https://www.nmhealth.org/publication/view/general/5112/ Norovirus Fact Sheet, English Norovirus Fact Sheet, Spanish
Clinical Description	Noroviruses are the leading cause of acute gastroenteritis which is sometimes referred to as “stomach flu” or “winter vomiting disease.” Illness is generally short-lived and self-limiting. Illness is characterized by acute onset of vomiting, watery, non-bloody diarrhea with abdominal cramps, and nausea. Some persons may experience only vomiting or diarrhea. Muscle aches, malaise, and headache are also commonly reported. Low-grade fever may be present. Symptoms usually last 24 to 60 hours. Dehydration is the most common complication. Up to 30% of infections may be asymptomatic.
Transmission, Exposure	Noroviruses are highly contagious. These viruses can remain viable and infective on surfaces for up to two weeks. Outbreaks are most commonly spread person to

	person. Humans are the only known reservoir. Noroviruses are found in the stool or vomitus of infected people or on contaminated surfaces not properly cleaned and disinfected.
Contagious Period	Ill persons are most contagious with the greatest amount of viral shedding during the illness and for 72 hours after symptoms end.
Incubation	Generally, 24 to 48 hours after ingestion of the virus; however, symptoms can appear as early as 12 hours after exposure.
Diagnosis	Diagnosis relies on the detection of viral RNA in stools or vomitus of affected persons, by use of reverse transcription-polymerase chain reaction (RT-PCR) assays.
Management of Case	Treatment is supportive with an emphasis on maintaining hydration. Most people recover completely within 1 to 2 days, with no long-term complications of norovirus illness.
Management of Contacts	Persons with suspected norovirus infection should be managed with standard precautions with careful attention to hand hygiene practices. Contact precautions should be implemented when caring for diapered or incontinent persons.
Public Health Action	Individual cases are not reportable, but outbreaks should be reported to the NMDOH at (505) 827-0006.
Prevention Education	Prevention requires good personal hygiene (hand-washing after using the toilet and changing diapers and before preparing food and eating).
School Action	• With acute diarrhea of any cause, prevent dehydration by increasing fluid intake. • Students with fever, vomiting, or diarrhea that interferes with school activity should be sent home and excluded from school until afebrile and diarrhea no longer interferes with normal activities.

	• Report outbreaks of diarrhea to the NMDOH immediately, especially if there is a suspicion of food or water transmission. • Frequent hand-washing should be stressed by all school staff. • Provide prevention education.

Pediculosis (Head Lice)

Condition, **Disease, Agent**	**PEDICULOSIS (HEAD LICE)** *Pediculushumanuscapitis, parasitic arthropod* Lice Fact Sheet, English Lice Fact Sheet, Spanish
Clinical Description	Head lice are parasitic insects with six legs and no wings. They hold onto head hair with specially adapted claws. They move swiftly on dry hair. Head lice feed by biting and sucking blood through the scalp. They very often cause itching, but this is not always the case, particularly when newly arrived to the head. Most cases are light – only about 10 lice on the head. Lice will not leave the scalp unless they are dead or dying. Head lice and their eggs are well camouflaged on the head. Healthy lice tend to stay close to the scalp as it is their feeding ground.
Transmission	Lice are spread by close head-to-head contact with someone who has head lice. Lice cannot jump, fly, or swim, but spread by climbing rapidly from head-to-head. Anyone with hair on the head can get lice. Head lice do not survive off the scalp for more than 48 hours. According to the American Academy of Pediatrics (AAP), head lice infestations have been shown to have low contagion in classroom (American Academy of Pediatrics 2012 Red Book, p. 546).
Contagious Period	Full grown lice move frequently between heads when they have the opportunity. Lice mature to the adult stage approximately 9–12 days after hatching. Lice nits (lice eggs) remain on the head where they hatch for a minimum of 6 days.
Incubation	Eggs hatch in 7–10 days and reach maturity in 6-14 days. At maturity they are fully

	capable of reproduction.
Diagnosis	Inspect for live crawling lice. Proper diagnosis of head lice is the most important step in controlling infestation. Most persons with head lice infestation will have between 10 and 20 lice.
Management of Contacts	School-wide head checks are no longer recommended. Educating parents and teachers on head lice is essential.
Public Health Action	Pediculosis is not a reportable condition.
School Action	• At the end of the school day, send students who have lice home. They may return to school after the first treatment is completed. • Provide educational material including treatment recommendation to parents. • Maintain confidentiality of the affected student and his/her family. • Mass screening of children for head lice has been shown to be ineffective. According to the American Academy of Pediatrics, "no-nit policies in schools are detrimental, causing lost time in the classroom, inappropriate allocation of the school nurse's time for lice screening, and a response to infestations that is out of proportion to the medical significance."

Pertussis (Whooping Cough)

Condition, **Disease, Agent**	**PERTUSSIS (WHOOPING COUGH)** *Bordetella pertussis, Bordetella parapertussis* *Pertussis* Pertussis Fact Sheet, English Pertussis Fact Sheet, Spanish

Clinical Description	Pertussis has three stages: the catarrhal stage with sore throat, coryza, mild cough, and low-grade or no fever lasts 1–2 weeks; the paroxysmal stage with increasingly severe spasms of cough with post-tussive whoop or vomiting lasting 2–6 weeks; and the convalescent stage with gradual lessening of coughing spasms disappearing in 2–6 weeks. Infants under six months of age may have apnea but no whoop. Complications may include pneumonia, seizures, encephalopathy, and death. Less serious complications are otitis media, anorexia, and dehydration.
Transmission, Exposure	Direct person-to-person by respiratory droplets or by direct contact with respiratory secretions from infected person.
Contagious Period	From onset of symptoms until three weeks of coughing; most contagious period is the first two weeks of cough.
Incubation	7–10 days with range of 4–21 days.
Diagnosis	Laboratory diagnosis is by PCR swabbing (polymerase chain reaction). Mild cases may be difficult to recognize unless they occur in contacts of typical disease.
Management of Case	Refer persons with severe or persistent cough for medical evaluation; persistent cough is a cough of more than 7 days duration. Even though they are still coughing, people are no longer considered infectious after 5 days of antibiotics. The cough may persist for weeks or months even after appropriate treatment. Students may need restriction of activity if they have exercise-induced spasms of coughing. Exclude suspect or confirmed cases until after 5 days of antibiotic treatment.
Management of Contacts	Identify close contacts and refer them for preventive treatment. The focus of identification and prophylaxis of high-risk contacts includes infants, pregnant women, immunocompromised individuals, and vaccine exemptors. Close contacts include those with direct face-to-face exposure within three feet of a coughing case, direct contact with respiratory, oral or nasal secretions or sharing confined space for a minimum of one hour with coughing case. All students under 7 years of age who have not completed the primary series or did not receive a booster dose

	after 4 years of age should receive a pertussis vaccine booster. All students 10 years of age and older who have not had a pertussis booster during past 5 years should receive a dose of Tdap; those with less than 5 years should be considered for Tdap depending on benefits and risks. Conduct surveillance for additional cases in the setting where a case exposed others for three weeks from the first date of exclusion of the case. Exclude cases while taking antibiotics for 5 days. The NMDOH will evaluate for high-risk contacts in the classroom situation before advising prophylaxis for classmates.
Immunization	For school entry, students are required to have completed at least four doses of pertussis-containing vaccine with one dose received on/after 4th birthday. Tdap is required for 7th and 8th grade entry and recommended for all higher grades and adults younger than 64 years, if more than 5 years since last pertussis-containing immunization. For case(s) occurring in a school, assess the vaccination status of all contacts and students in the same school as the case: • Exposed children less than 7 years of age who have received their third dose of DTaP 6 months or more before exposure should be given a 4th dose. • Exposed children less than 7 years of age who received all four primary doses before their fourth birthday should receive a fifth (booster) dose of DTaP. • Persons 7–9 years of age who have not been fully vaccinated against pertussis should receive Tdap. • Those 10 years of age or older who have not received Tdap should get it. • No minimum interval between doses of Td and Tdap. • Recommendation is that pregnant women who have not previously received Tdap be vaccinated with Tdap during the late 2nd or 3rd trimester (> 20 weeks gestation). Alternatively, if not administered during pregnancy, Tdap should be administered immediately postpartum.

	• All adults should have documentation of one dose of Tdap. If adults have not received one dose of Tdap, they should receive it as soon as possible, particularly those who will have contact with infants. • Vaccine exemptions within affected schools should be identified and reported to NMDOH for exclusion determination.
Public Health Action	Report suspected and confirmed cases to the NMDOH. The Epidemiology and Response Division will coordinate testing, contact identification and treatment.
School Action	• Exclude cases and symptomatic contacts until completion of 5 days of antibiotic treatment or until three weeks after onset of cough if not treated. • Refer suspected cases for medical evaluation and treatment immediately and monitor school for additional cases for 21 days after last contact with known case(s). • Report confirmed and suspect cases to NMDOH (505-827-0006), who will coordinate follow up and parental notification. • Review immunization status of students and staff to identify susceptible contacts. • Provide access to immunization. • Provide prevention education.

Plague

Condition, Disease, Agent	**PLAGUE** *Yersinia pestis* (bacteria) Plague Fact Sheet: English Plague Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5120

Clinical Description	Plague is a flea-transmitted bacterial infection to humans through rodents. The most common form is bubonic plague; less common forms are septicemic and pneumonic. Bubonic plague: The primary site of inoculation may resemble an infected insect bite or the site may be unapparent. The regional lymph nodes become enlarged and exquisitely tender (bubo). Most patients have fever and non-specific flu-like symptoms (vomiting, diarrhea). Untreated patients with bubonic plague may develop (secondary) bacteremia. Untreated bubonic plague has a case fatality rate of 50–60% and is the most common form of plague. Septicemic plague: High fever with malaise and other non-specific symptoms occur, but no bubo is present to clinically distinguish symptoms from sepsis due to other agents. Pneumonic plague: This condition may develop following bacteremia with cough and production of bloody sputum and can be spread person-to-person via airborne transmission. Untreated pneumonic plague is almost always fatal. Plague pharyngitis: May resemble tonsillitis. Plague should be considered in any patient who presents with fever and acute lymphadenitis and resides in a known plague area. Plague is treatable but has a high fatality rate with inadequate or delayed treatment.
Transmission, Exposure	Humans infected by: (1) bite from a plague infected flea, (2) bite or contact with respiratory secretions from a person or animal, often a domestic animal that has pneumonic plague, (3) contact with tissues from an infected animal such as a rodent, rabbit, or coyote, (4) ingestion of raw or undercooked meat of infected animal.
Contagious Period	Pneumonic plague – from onset of cough until completion of several days of antibiotic therapy. Bubonic and septicemic plague – usually not contagious.
Incubation	2–8 days for bubonic plague; 1–6 days for human-to-human transmission of pneumonic plague.
Diagnosis	Plague may resemble wound infections with secondary lymphadenitis; any patient presenting with these symptoms and living in known plague area should be

	evaluated for plague. Cultures should be obtained from blood and apparent sites of infection (such as the affected lymph node).
Management of Case	All suspect plague cases should be treated immediately with appropriate antibiotics. Pneumonic cases and contacts should be treated with antibiotic therapy and kept under surveillance. They should be excluded from school until completion of 48 hours of antibiotics and there is favorable clinical response. School exclusion of bubonic and septicemic plague cases is not appropriate.
Management of Contacts	Any suspect plague case should be referred immediately for medical evaluation. Contacts of pneumonic plague case should be given antibiotic prophylaxis immediately and be kept under surveillance for development of illness. Close contacts of all plague patients may have had the same environmental exposure and should be considered for prophylaxis or surveillance.
Prevention Education	Reduce rodent activity near homes and schools; control fleas on domestic animals; avoid contact with dead or ill animals; rodent-proof houses and outbuildings; wear rubber gloves when handling wild game; stack wood piles 12 inches above ground and 100 feet away from house.
Public Health	Report cases or suspect cases immediately to the NMDOH (505-827-0006).
School Action	• Refer possible cases immediately for medical evaluation. • Exclude from school pneumonic cases until completion of 48 hours of antibiotic; do not exclude septicemic or bubonic cases unless ill. • Assist in identifying close contacts; contacts need not be excluded from school unless they are symptomatic of pneumonic plague. • Report rodent activity to the NMDOH (especially prairie dogs and ground or rock squirrels) on or near school grounds, as well as unusual numbers of dead rodents in the area.

Rubella

Condition, Disease, Agent	**RUBELLA (GERMAN MEASLES, THREE-DAY MEASLES)** *Rubivirus* *Rubella (German Measles)*

	Fact Sheet: English Rubella Fact Sheet: Spanish RUBEOLA
Clinical Description	A diffuse maculopapular rash is often the first sign of rubella disease; however, a mild prodromal illness, with low-grade fever, malaise, coryza, conjunctivitis and headache may occur 1–4 days before the rash appears. It appears first on the face but spreads rapidly over the entire body. The rash consists of small, flat (nonpalpable), reddish-pink spots that rarely last more than 3 days. Adolescents and adults with rubella may have arthritis affecting a few joints and lasting a few days or weeks. Congenital rubella varies in severity from subclinical to combinations of microcephaly, mental retardation, cataracts, deafness, and heart defects.
Transmission, Exposure	Droplet or contact transmission by nasal pharyngeal secretions or urine from congenital rubella cases, crossing placenta and infecting fetus in infected pregnant women.
Contagious period	A few days before the rash develops to 5 to 7 days after the rash begins: 1 year or longer after birth in congenital rubella cases for urine transmission.
Incubation	Usually 16 to 18 days with range of 14–23.
Diagnosis	Case definition consists of 1) acute onset of maculopapular rash, 2) temperature greater than 99.0^{O} F, 3) arthralgia/arthritis, lymphadenopathy, or conjunctivitis, and 4) laboratory confirmation. Confirmation by serology is essential. Virtually all patients will have specific rubella IgM antibody during the acute illness. Confirmation of acute infection may require paired sera.
Management of Case	There is no specific treatment. School exclusion is appropriate for 7

	days after onset of rash.
Management of Contacts	Contacts known to be susceptible should be immunized immediately. Adult contacts born before 1957 are presumed to be immune; others may be tested for immunity if test results will be available within 24 hours (so that immunization will not be delayed). Pregnant women should contact their medical provider immediately. Exclusion from school not appropriate.
Immunization	Two doses of rubella (MMR) vaccine are required for school entry. Pregnant females should not be vaccinated but may be considered for IG prophylaxis. All age-appropriate females should be counseled to avoid pregnancy for three months after immunization.
Public Health Action	All suspect and confirmed cases should be reported immediately to the NMDOH (505-827-0006). Identification and immunization of susceptible contacts will be coordinated by the Epidemiology and Response Division.
School Action	• Refer all suspected cases for medical evaluation. • Exclude infected students from school until 7 days after onset of rash. • Do not exclude contacts unless symptomatic. • Enforce 2-dose MMR immunization requirement for school entry. • Immediate notification of NM NMDOH of suspect and confirmed cases. • Provide prevention education to include risk of immunization regarding pregnancy and concerns for pregnant contacts.

Rubeola

Condition, Disease, Agent	**RUBEOLA (MEASLES)** *Rubeola* virus

	https://www.nmhealth.org/publication/view/general/5093 Fact Sheet: English https://www.nmhealth.org/publication/view/general/5094 Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5095
Clinical Description	Acute onset of fever, coryza, non-exudative conjunctivitis, cough and rash which usually begins on the second or third day of illness characterizes measles. The rash begins on the face or neck under the hairline or behind the ears and progresses to the trunk and extremities over 1–2 days. The rash is red and maculopapular with some clustering which tends to become confluent on the face. Koplik's spots may be present inside the mouth. Potential complications include otitis media, pneumonia, croup, diarrhea, and encephalitis. Immune-impaired children and adults usually have more severe illness and a higher risk of complications.
Transmission, Exposure	Droplet and airborne transmission of respiratory secretions that may circulate in the air up to 4 hours after infected person leaves a room. **Measles is one of the most highly-contagious infectious diseases.**
Contagious Period	1–2 days before onset of initial symptoms; 3–5 days before onset of rash until 4 days after appearance of rash.
Incubation	Average of 10 days from exposure to onset of rash with a range of 7–18 days or 8–12 days from exposure to onset of symptoms; usually 14 days from exposure until rash appears.
Diagnosis	Clinical evaluation with history of symptoms is useful with confirmation by lab culture of respiratory secretions.
Management of Case	Refer suspect cases immediately for medical evaluation. There is no specific treatment. School exclusion is appropriate until 4 days after rash

	onset.
Management of Contacts	Immunization records should be reviewed to determine susceptible contacts and access to immunization should be provided within 72 hours of exposure. Immune globulin may be given to susceptible contacts who should not receive vaccine, including pregnant females and those who refuse vaccination. Susceptible contacts should be excluded from school until 21 days after rash onset in the last case contact unless they receive a dose of measles vaccine within three days of exposure. Susceptible individuals who were given post-exposure preventive treatment with immune globulin should be excluded until 21 days after rash onset in the last case contact.
Immunization	Two doses of measles vaccine (MMR) are required for school entry.
Public Health Action	All suspect and confirmed cases should be reported immediately to the NMDOH (505-827-0006). Identification and immunization of susceptible contacts will be coordinated by the Epidemiology and Response Division.
School Action	• Refer suspect cases immediately for medical evaluation. • Report confirmed and suspected cases immediately to the NMDOH. • Exclude cases from school until 4 days after onset of rash. • Review immunization records to identify susceptible individuals. • Exclude susceptible individuals until 21 days after onset of rash in the last case. • Provide prevention education including risks in pregnancy.

Scabies

Condition, Disease, Agent	**SCABIES** *Sarcoptes scabiei* Fact Sheet: English https://www.nmhealth.org/publication/view/general/5042

	Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5043
Clinical Description	Lesions caused by infestation of scabies mites are characterized by an intensely pruritic, red, vesiculopapular eruption caused by adult female mites burrowing under the skin to lay eggs. The scabies burrow appears as a gray or white thread-like line. Lesions are commonly found on finger webs, wrists and elbows, axillary folds, belt line; in men on thighs and external genitalia; and women on nipples, abdomen, and lower portion of buttocks.
Transmission, Exposure	Direct, prolonged contact, including sexual contact, with infected skin.
Contagious Period	Until mites and eggs are destroyed by treatment.
Incubation	Four to six weeks in people without previous exposure. People who have been previously infested develop symptoms 1–4 days after re-exposure.
Diagnosis	Exam shows typical excoriated papules and burrows. Microscopic exam of skin scrapings shows the mite, eggs, and fecal deposits.
Management of Case	Infested students should be excluded from school until initial treatment is completed. Treatment: with nonprescription formula containing permethrin is recommended; lindane solution is an alternative if retreatment is necessary but it is more toxic. Clothing and bed linens used by the patient in the three days prior to initiation of treatment should be laundered in hot water. Items that cannot be washed should be isolated in plastic bags for 10–14 days. The mites cannot survive more than three days without skin contact. Environmental disinfection is unnecessary and unwarranted.
Management of Contacts	Close contacts should be examined for signs of infestation. Household contacts are usually also infested and need treatment; therefore, all members of household should be treated concurrently to prevent reinfestation. Manifestation of infestations can appear as late as six weeks after exposure, during which time infected person can transmit scabies.
Public Health Action	Not a reportable condition; assistance with treatment available at Public Health Offices.

School Action	• Exclude infested students at the end of the school day until they have received initial treatment. • Examine close contacts for infestation. • Provide prevention education including material regarding treatment recommendations.

Streptococcal Infections (Strep Throat)/Scarlet Fever

Condition, Disease, Agent	**STREPTOCOCCAL INFECTIONS (STREP THROAT))/SCARLET FEVER** *Streptococcus pyogenes* Group A https://www.nmhealth.org/publication/view/general/5136 Fact Sheet: English https://www.nmhealth.org/publication/view/general/5207 Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5208
Clinical Description	Classic strep throat is characterized by severe sore throat, malaise, toxicity, fever, tender lymph nodes in the neck, and a purulent exudate on the tonsils. Untreated strep throat develops complications including otitis media, sinusitis, and abscesses on the tonsils and pharynx. Scarlet fever is strep throat plus a characteristic fine, sand-papery erythematous rash prominent on the cheeks, trunk, and extremities but less evident around the mouth, inside elbows, and behind knees. Invasive streptococcal infections may follow wound infections, including infected varicella lesions, or respiratory infections.
Transmission, Exposure	Transmitted person-to-person mainly via respiratory secretions; recurrent disease from ongoing contact with carriers.
Contagious Period	Weeks to months; 10–21 days after acute illness or until 14 hours after treatment.

Incubation	2 to 5 days for pharyngitis.
Diagnosis	Rapid strep test from throat swab or throat culture supports clinical evaluation.
Management of Case	Suspect cases should be referred for medical evaluation. Referral is urgent if high fever, marked toxicity, or respiratory distress is present. School exclusion recommended until at least 24 hours after antibiotic treatment initiated.
Management of Contacts	For sporadic cases of uncomplicated streptococcal infection, surveillance for additional cases is adequate.
Public Health Action	Report cases of scarlet fever, streptococcal toxic shock syndrome, or invasive streptococcal disease and outbreaks of streptococcal disease within schools to the NMDOH (505-827-0006).
School Action	• Refer suspect cases for medical evaluation and treatment. • Exclude cases until the infected individual has been on antibiotic treatment for at least 24 hours. • Report complicated cases and outbreaks of streptococcal infection to the NMDOH. • Provide prevention education.

Tetanus

Condition, Disease, Agent	**TETANUS** *Clostridium tetani* *https://www.nmhealth.org/publication/view/general/5137/*

	Tetanus Fact sheet, English Tetanus Fact Sheet, Spanish
Clinical Description	Tetanus, or "lockjaw," is caused by a neurotoxin produced by *Clostridium tetani*. Although tetanus occurs worldwide it is rare in the US due to immunization. Tetanus infection usually occurs from a skin wound. The wound that harbors *C. tetani* frequently is a minor one. Evidence of frank wound infection is likely to represent infection by other bacteria. Localized tetanus consists of painful tonic muscle spasms in the area of a wound and can precede generalized tetanus which presents with muscle spasms. Muscle spasms often produce trismus (inability to open the mouth fully or at all).
Transmission, Exposure	Contact of a wound in the skin with material containing tetanus spores. Contaminated wounds, deep wounds, or wounds with devitalized tissue are at greatest risk. Tetanus spores are everywhere in the environment.
Contagious Period	Not communicable from person to person.
Incubation	Most cases occur within 8–10 days of exposure: ranging from 3 to 21 days.
Diagnosis	The diagnosis should be made based on clinical presentation and exclusion of other possibilities. Culturing of wounds is low yield; treatment should not be based on laboratory evidence.
Management of Case	Tetanus is a medical emergency requiring hospitalization. All wounds should be properly cleaned and debrided. Tetanus immune globulin (TIG) is recommended for treatment and tetanus booster vaccination if needed. Antibiotic treatment as indicated may be provided. Supportive care and pharmacotherapy to control spasms also may be necessary.
Management of Contacts	Not indicated, since not spread person-to-person.

Public Health Action	Report suspected cases to the NMDOH (505-827-0006).
School Action	• Refer suspected cases for medical evaluation and treatment. • Assure appropriate immunization status for all students. • For wounds, make sure appropriate treatment is given. • Provide prevention education.

Tinea Capitis, Corporis, Cruris, and Pedis

Condition, Disease, Agent	**TINEA CAPITIS, CORPORIS, CRURIS, and PEDIS (Ringworm fungal infection of scalp, body, groin and feet)** *Microsporum* and *Trichophyton* Fact Sheet: English https://www.nmhealth.org/publication/view/general/5040 Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5041
Clinical Description	Tinea lesions are generally circular, reddish, crusty, and scaly, with a vesiculopapular border; they occur on the face, scalp, and body. Lesions are often itchy. Tinea capitus may present with patchy areas of dandruff-like scaling and hair loss; discrete areas of hair loss with stubs of broken hair; numerous scaly pustules; or a kerion (boggy mass).
Transmission, Exposure	Direct or indirect contact with skin or scalp lesions of infected persons or animals; potentially any surface, especially moist surfaces.
Contagious Period	As long as lesions are present; viable fungus may persist on contaminated materials for long periods.
Incubation	Unknown, estimated to be 10–14 days.
Diagnosis	Fungal culture and potassium hydroxide wet mount of scrapings from skin lesions.

Management of Case	Refer suspect cases for medical evaluation and treatment. Scalp lesions require oral therapy for at least four weeks. Other varieties require topical or oral antifungal therapy Students should avoid public areas conducive to transmission such as gyms and swimming pools. School exclusion is not necessary especially if skin (not scalp) lesions can be covered by clothing or a loose dressing until treatment has been initiated.
Management of Contacts	Examine close contacts including household pets by visual examination of the skin and scalp. Monitor contacts as long as potential for exposure continues.
Public Health Action	Not a reportable condition.
School Action	• Refer suspect cases for medical evaluation and treatment. • School exclusion is not necessary. • Observe contacts for development of lesions. • Decontaminate sports equipment or wading pools where the fungus may grow. • Encourage covering of lesions. • Discourage sharing of personal items with infected case. • Provide prevention education.

Tuberculosis (TB)

Condition, Disease, Agent	**TUBERCULOSIS (TB)** *Mycobacterium tuberculosis* CDC Fact sheets: https://www.cdc.gov/tb/topic/basics/default.htm
Clinical Description	Primary infection in children may produce non-specific symptoms of fever, weight loss and cough. Reactivation of infection in adolescents or adults produces an enlarging cavity in the lung containing large numbers of bacteria. Active pulmonary tuberculosis causes chronic cough with purulent, often blood tinged

	sputum. Chest pain may be present especially if the pleura is involved. Systemic symptoms are common including fatigue, weight loss, night sweats and fever.
Transmission, Exposure	Mycobacterium tuberculosis is transmitted in **airborne particles called droplet nuclei** that are expelled when persons with pulmonary or laryngeal TB cough, sneeze, shout, or sing. The tiny infectious particles can be carried by air currents throughout a room or building. Transmission usually occurs with close contact to the active case over a period of time and depends on the number of bacteria present in secretions, efficiency of coughing, and closeness of contact.
Incubation	2–12 weeks from exposure to development of positive tuberculin test; clinical disease most likely within first 2–3 years after infection but may occur decades later.
Contagious Period	Throughout period of active infection until 1–3 weeks after initiation of effective treatment.
Diagnosis	Physical examination may be suggestive of tuberculosis, especially if the individual is known to have been exposed. A positive TB test means that the person has been infected with *M. tuberculosis* or has received BCG vaccine, but does not indicate if the infection is active. The diagnosis of active TB is made by sputum culture (or other specimens) and chest imaging.
Management of Case	For active TB disease, completion of treatment is critical to prevent relapse and development of secondary drug resistance. Active disease cases should be excluded from school until released by the NMDOH Tuberculosis (TB) Prevention Program, usually after two weeks of completed therapy and coughing has subsided.
Management of Contacts	The NMDOH TB Prevention Program will coordinate testing and determine the need for chest x-ray, physician evaluation, and preventive treatment of contacts.
Vaccine	BCG vaccine is administered in parts of the world where there is a high risk of childhood TB, but it is not used in the United States.

Public Health Action	All active cases of tuberculosis should be reported to the NMDOH. Children who are positive tuberculin reactors should be referred also since infection in a child indicates recent exposure to an active case. The Tuberculosis Prevention Program will coordinate contact evaluation.
School Action	• Refer students and staff with chronic cough lasting longer than three weeks for medical evaluation. • Report suspected or confirmed cases to the NMDOH. • Exclude students and staff with active tuberculosis from school until determined by the NMDOH TB Prevention Program to be non-contagious. • Provide preventive education.

Tularemia

Condition, Disease, Agent	**TULAREMIA** *Francisella tularensis* https://www.nmhealth.org/publication/view/general/5140 Fact Sheet: English https://www.nmhealth.org/publication/view/general/5141 Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5142
Clinical Description	Tularemia is also known as rabbit fever. People usually become infected through tick or deer fly bites or by handling infected animals. The common symptoms of tularemia include sudden onset of high fever, chills, fatigue, general body aches, headache, nausea, and a skin ulcer at the site of entry.
Transmission, Exposure	Most humans acquire tularemia through handling infected rabbits or rodents, or from deer fly or tick bites.
Contagious Period	Not communicable from person to person.
Incubation	Related to size of inoculum, usually 3–5 days with a range of 1–21 days.

Diagnosis	Diagnosis is done with a single positive serologic test result and confirmed by a four-fold rise in total antibody titer with a second specimen obtained two or more weeks later. Diagnosis of tularemia usually is confirmed by culture of *F. tularensis*.
Management of Case	Tularemia is treatable with antibiotics. Prompt diagnosis and treatment are critical for preventing tularemia from progressing to more serious clinical forms. When human tularemia is suspected on clinical and epidemiological grounds, appropriate specimens for diagnosis should be obtained immediately, and the patient should be started on specific antimicrobial therapy pending laboratory confirmation.
Management of Contacts	Not indicated, since not spread person-to-person.
Public Health Action	Report suspected cases to NMDOH (505-827-0006).
School Action	• Preventive measures include avoidance of tick and deer fly bites. • Prevention education. • Avoid contact with dead and sick animals.

Upper Respiratory Tract Infection, Acute Viral

Condition, Disease, Agent	**UPPER RESPIRATORY TRACT INFECTION, ACUTE VIRAL** Numerous viruses, including adenoviruses, coronaviruses, enteroviruses and rhinoviruses Fact Sheet: English https://www.nmhealth.org/publication/view/general/5167 Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5168
Clinical Description	Rhinoviruses are the most frequent cause of the common cold. Signs and symptoms of upper respiratory tract infections include nasal discharge, nasal

	congestion, sneezing, cough, and low-grade fever. Otitis media and pharyngitis can also occur, depending on the causative agent.
Transmission, Exposure	Occurs primarily through person-to-person contact, with self-inoculation by contaminated secretions on hands and/or aerosol spread. Some viruses can also be spread via aerosol and indirect contact.
Contagious Period	Most communicable during the first few days of acute illness.
Incubation	Depends on the causative virus, varies from 2–14 days.
Diagnosis	Usually, clinical diagnosis is done. Testing, depending on the type of virus, is available for some viruses, although testing is not widely used for typical URIs.
Management of Case	Children and adults with clinical illness should be sent home until fever (greater than 100.4° F) subsides. Fluids are important to maintain hydration. Bed rest and analgesics/antipyretics (other than aspirin) may help symptomatically.
Management of Contacts	No specific recommendations other than using good techniques to avoid spreading illness. All individuals at risk for complications from respiratory illness or in contact with persons at increased risk should receive influenza vaccine annually as soon as it is available each year. Encourage good hand hygiene and appropriate disposal of contaminated articles.
Public Health Action	Notify the NMDOH (505-827-0006) when outbreaks of respiratory disease appear in a school.
School Action	• Exclude students and staff with respiratory illness until afebrile (less than 100.4°F) and symptoms do not affect participation in routine school activities. • Report suspected outbreaks of respiratory disease to the NMDOH.

	• Emphasize hand-washing and respiratory droplet precautions in prevention education. • Provide prevention education.

West Nile Disease

Condition, Disease, Agent	**WEST NILE DISEASE** *Flavivirus* *https://www.nmhealth.org/publication/view/general/5103/* Fact Sheet: English https://www.nmhealth.org/publication/view/general/5104/ Fact Sheet: Spanish https://www.nmhealth.org/publication/view/general/5105/
Clinical Description	Inapparent disease and mild infection are common. Signs and symptoms vary in severity from mild fever to aseptic meningitis, to encephalitis with coma, paralysis, and death. The elderly are at greatest risk of severe illness with West Nile Virus. Disease in humans is most common in summer and early fall. Symptoms are quite variable depending on the virus and the age and general health of the case. Mild cases often occur as a febrile headache or aseptic meningitis.
Transmission, Exposure	Transmission is by the bite of infected mosquitoes that have acquired the virus from feeding on infected birds. Birds have the virus for only a few days, but mosquitoes remain infected for life.
Contagious Period	Not transmitted from human-to-human.

Incubation	Incubation period is usually 2–14 days, up to 21 days in immunocompromised people.
Diagnosis	
Management of Case	No antiviral medication is available. Supportive therapy is indicated.
Management of Contacts	None indicated.

Sexually Transmitted Diseases (STDs)

Introduction

STDs are common infections in the United States and in New Mexico. New Mexico currently has one of the highest rates of chlamydia in the nation. Rates of gonorrhea and chlamydia are highest in people 15 to 24 years of age. Other sexually transmitted infections, such as syphilis, occur in the teenage population but are less common.

Studies have shown that about 40% of teenagers have had intercourse by the time they finish high school (2019 YRBS data[1]). Teenagers often practice "serial monogamy" and therefore may have several sex partners in a given year. Many teenagers do not use contraception and many are not using condoms to protect themselves from infections. These are factors that help to explain the high STD rates among our teenage population. School nurses can be a valuable resource for information about sexuality, contraception, and STDs. Information on specific STDs can be found at: CDC - STD Fact Sheets.

School Nurse Education

School Nurses can help address concerns by conveying a simple and nonjudgmental message to those students with whom they interact:

- Delay having sexual intercourse until you are ready. It is important to remind teenagers that not every teen is sexually active.
- Use condoms to prevent STDs.
- Use reliable contraception such as birth control pills or a long-acting progesterone injection (Depo) or implant (Nexplanon).
- Limit number of sexual partners.
- Encourage students to talk to their parents about sexual issues such as their sexual feelings, intimate relationships, sexually activity, birth control, and STDs. Sometimes students simply need encouragement to open lines of communication with a parent or relative about these subjects.
- In situations where students are fearful of parental reactions (punishment/violence), the School Nurse can be of assistance in referring the student to proper medical or counseling interventions.

The School Nurse can also help students by letting them know that they are legally entitled to receive confidential medical services for family planning and STDs. School-Based Health Centers (SBHC) and local Public Health Offices provide free and ***confidential*** STD services, prevention services (condoms), and family planning services. It is helpful for school nurses to know the public health nurses in their communities, in order to facilitate referrals, especially in a crisis or emergency.

When questioning a student about sexual activity, it is best to ask directly whether the student has sexual partners who are males, females, or both.

Students who present to the School Nurse with possible symptoms of a STD should be asked about their risks for STDs and referred to a medical facility for diagnosis and treatment.

STD Signs and Symptoms

STD signs and symptoms may occur in areas other than the genitals, depending on the type of sexual exposure. Many STDs have no symptoms or may have vague and non-specific symptoms, especially in girls.

Male:

- Penile discharge.
- Any sore, growth, or ulcer on the penis or groin area.

Female:

- An abnormal vaginal discharge.
- A sore, growth, or ulcer on the external or internal genitalia.
- Pain with intercourse.
- Abnormal vaginal bleeding.
- Lower abdominal pains with or without vomiting, nausea, or fever.

Either gender:

- Unusual rashes, especially on the palms or soles (concerning for syphilis).
- Sore throat (in the case of receptive oral intercourse).
- Burning with urination.
- Rectal discharge and/or discomfort.
- Sores, growths, or ulcers in the rectal area.
- Sore and swollen cervical or inguinal lymph nodes.

Public Health Services

Every county in New Mexico has at least one public health office where people with STDs may be evaluated. Disease Intervention Specialists provide STD outreach and follow up services through public health offices across the state. Public Health Offices provide free and confidential STD and family planning services for teens. Minors do not need parental consent for family planning services or STD evaluation and treatment (including HPV vaccine).

Reporting Suspected Abuse

If sexual abuse or inappropriate sexual contact is suspected, report it to Children, Youth, and Families Department (CYFD) or other appropriate authority. Every person who knows or has reasonable suspicion that a child is being abused or neglected in New Mexico must report the matter immediately to CYFD's Statewide Central Intake child abuse hotline **(1-855-333-SAFE [7233] or #SAFE from a cell phone)**, or to law enforcement or the appropriate tribal authority.

Chlamydia, Gonorrhea

Condition, Disease, Agent	**CHLAMYDIA, GONORRHEA** *Chlamydia trachomatis* (CT, bacteria-like); *Neisseria gonorrhoeae* (GC, bacteria) CDC Chlamydia Fact Sheet, English CDC Chlamydia Fact Sheet, Spanish CDC Gonorrhea Fact Sheet, English CDC Gonorrhea Fact Sheet, Spanish
Clinical Description	These infections are described together because there is overlap in the clinical presentation, and dual infections are common. CT and GC infect mucous membranes resulting in inflammation with burning on urination and urethral or vaginal discharge; infections of other sites may cause sore throat, conjunctivitis,

	rectal pain, and discharge. Complications include pelvic inflammatory disease (PID) in women and epididymitis in men. PID is responsible for an epidemic of tubal infertility and ectopic pregnancy in the US. Disseminated GC with arthritis, tenosynovitis and skin lesions occurs infrequently.
Transmission, Exposure	Both are readily transmitted by intimate (mucosal) contact with infectious secretions. CT conjunctivitis can be caused by self-inoculation of the eye by a person with genital infection. It is readily transmitted by sharing eye makeup. Sexual contact with an infected individual may result in genital, throat, and rectal infections.
Contagious Period	If untreated, the infected individual may remain contagious indefinitely; after treatment, the contagious period is one to several days.
Incubation	GC is 2–5 days after exposure; CT is 7–14 days.
Diagnosis	Examination may reveal inflammation (tenderness, swelling, pus discharges) of the infected genitals or eyes. Laboratory testing by DNA probes is highly sensitive and specific. Bacterial culture for GC is recommended.
Management of Case	Suspected cases should be referred for medical evaluation and treatment. Minors may seek care for sexually transmitted disease without parental knowledge or consent. In addition to GC and chlamydia, at risk individuals should be evaluated for other sexually transmitted diseases. Gonococcal and chlamydial infections in young children indicate inappropriate sexual contact. Refer children under the age of consent and older children who give a history of sexual assault to CYFD and/or other appropriate authority.
Management of Contacts	Intimate (sexual) contacts of infected individuals should be evaluated for infection and treated.
Preventive Education	Postpone sexual activity and limit partners; use condoms. Nonoxynol spermicides have some antimicrobial effect and may enhance the efficacy of condoms.
Public Health Action	Report gonorrhea and chlamydial infections to the NMDOH/STD Program via morbidity fax: (505) 476-3638.
School Action	• Support school-based clinics, peer counseling, and education to increase health care services for adolescents.

	• Refer students to a physician, NMDOH or school-based clinic for diagnosis and treatment. • School exclusion is not necessary. • Consider the possibility of child or sexual abuse and refer to CYFD as appropriate. • Provide prevention education to include safer sex practices.

Herpes Simplex Genital Infection

Condition, Disease, Agent	**HERPES SIMPLEX GENITAL INFECTION** *Herpes simplex virus (HSV), type 2* CDC Genital Herpes Fact Sheet, English CDC Genital Herpes Fact Sheet, Spanish
Clinical Description	Symptoms include vesicles (small blisters) on the skin and/or mucus membranes that rupture quickly leaving painful ulcers and dry crusts (on skin); satellite vesicles form for several days with primary infection. There may be fever and malaise lasting 5 or more days following infection. Recurrent infections are common and usually occur in the same area as the primary lesion. Recurrent genital lesions may be initiated by trauma, emotional stress, menstruation, illness, or fever. Recurrent lesions are usually smaller and heal more quickly.
Transmission, Exposure	Direct contact with genital secretions or lesion; indirect contact highly unlikely although virus remains viable on contaminated objects at least for several hours.
Contagious Period	7–50 days following onset of primary infection and typically 3–4 days after onset of recurrent episode; during asymptomatic shedding of the virus.
Incubation	2–12 days for primary infection.
Diagnosis	Diagnosis is made on the clinical evaluation of lesions that are initially thin-walled vesicles and/or blisters that ulcerate on moist surfaces or crust on dry skin; laboratory testing includes cultures.

Management of Cases	Refer for medical evaluation for apparent primary infection or for frequent or severe recurrences. Genital herpes in a student may be indicative of sexual abuse. Specific treatment: Oral (or in severe cases, intravenous) acyclovir is effective in shortening the duration of the primary and recurrent episodes including viral shedding. Those with frequent recurrences may suppress them with continuous oral acyclovir. Valacyclovir and famiciclovir are newer medications that may be used in these cases.
Management of Contacts	Refer contacts for medical evaluation and provide prevention education.
Public Health Action	Not reportable condition.
School Action	• Support school-based clinics, peer-counseling, education, and other measures to increase availability and acceptability of health care services to adolescents. • Affected students should not be excluded from school. • If sexual abuse or inappropriate sexual contact is suspected, report to Child Protective Services or other appropriate authority. • Provide prevention education to include safer sex practices.

HIV Infection/AIDS (Acquired Immunodeficiency Syndrome)

Condition, Disease, Agent	**HIV INFECTION/AIDS (ACQUIRED IMMUNODEFICIENCY SYNDROME)** *Human immunodeficiency virus (HIV)* CDC information: https://www.cdc.gov/hiv/basics/index.html
Clinical Description	Initial infection with HIV may be subclinical or may cause an acute mononucleosis-like illness with fever, malaise, sore throat, lymph node enlargement, and skin rash. HIV infects cells of the immune system and causes progressive impairment of immune function. Antiretroviral treatment (ART) has

	prolonged the symptom-free period, delayed the onset of AIDS, and prolonged the lives of HIV infected people.
Transmission, Exposure	HIV can transmit through contact with blood, sexual contact, or through sharing injection equipment with an infected person. HIV can be transmitted from a mother to her baby during pregnancy, birth, or breastfeeding. HIV is not transmitted through casual household, school, or social contact or through contact with tears, sweat, or saliva.
Contagious Period	Early in infection to indefinitely since infection is chronic. People on ART who have an undetectable viral load will no longer transmit the virus through sex. Perinatal transmission is less likely for mothers on ART with an undetectable viral load.
Incubation	1–3 months to seroconversion for HIV infection. One to many years for the development of AIDS.
Diagnosis	HIV infection can be suspected clinically, but diagnosis requires laboratory confirmation. There are three types of HIV tests: antibody tests, antigen/antibody tests, and nucleic acid tests (NAT).
Management of Case	Students with HIV infection may be absent from school frequently and may need medication regularly at school. They may be more susceptible to some infections and may not be completely protected by immunizations. Observing standard precautions with these students is especially important.
Management of Contacts	Post-exposure preventive treatment (PEP) is recommended for any percutaneous exposure to blood from a person with known HIV infection. This antiretroviral treatment must be started within 72 hours of exposure to be optimally effective. Such contacts should be referred for medical evaluation immediately. Any person at risk of HIV infection should be tested to facilitate early treatment.
Public Health Action	Report cases of HIV infection or AIDS to the NMDOH. Refer exposures who are uninsured to the DOH/STD Program at (505) 476-3136 immediately for post-exposure preventive treatment and testing.
Prevention Education	Avoid contact with blood and body fluids; avoid injections, tattoos, etc. with unsterile equipment. Practice safe sex. Persons who inject illicit substances (including steroids) should be encouraged to stop or to obtain sterile needles and equipment through the Harm Reduction Program at their local PHO. Practice standard precautions.

School Action	• School exclusion is not appropriate (possible exceptions may occur with opportunistic infections (e.g., TB). Infected students may participate in all school activities compatible with their medical condition. • Practice standard precautions and conform to OSHA regulations. • Monitor students for behavior that may place others at risk (biting for example). • Provide prevention education. • Protect confidentiality of infected persons and provide with as normal a school environment as possible.

Human Papillomavirus (Genital HPV)

Condition, Disease, Agent	**HUMAN PAPILLOMAVIRUS (GENITAL HPV)** *Human Papillomavirus (HPV)* CDC Genital HPV Fact Sheet, English CDC Genital HPV Fact Sheet, Spanish
Clinical Description	Single or massed warty or cauliflower-like growths may be found on external genitals, urethral opening, anus, and inside the vagina. They may cause irritation. Some strains cause neoplasia of the cervix and other genital structures.
Transmission, Exposure	Person-to-person genital contact and possibly by contaminated articles.
Contagious Period	May be indefinite but probably at least as long as lesions exist.
Incubation	2–3 months with a range of 1–20 months.
Diagnosis	The typical lesion usually confirms diagnosis, but it can be excised and examined histologically. Microscopic examination of cells is an effective method for detecting cellular abnormalities associated with malignancy in women.
Management of Case	Treatment which may be chemical or physical destruction will decrease the amount of wart virus available for transmission. The warts may regress spontaneously within months to years. Avoidance of direct contact with lesions

	by others prevents transmission. Studies have indicated that the male condom does not prevent infection. School exclusion is not appropriate.
Management of Contacts	Sexual contacts of patients with venereal warts should be examined and treated if indicated.
Prevention Education	Avoidance of contact with lesions on another person prevents infection. HPV vaccine is effective if initiated before sexual debut of student.
Public Health Action	Not reportable to the NMDOH.
School Action	• School exclusion is not appropriate. • Provide prevention education as part of sex education curriculum.

Trichomoniasis

Condition, Disease, Agent	**TRICHOMONIASIS** *Trichomonas vaginalis* CDC Trichomonas Fact Sheet, English CDC Trichomonas Fact Sheet, Spanish
Clinical Description	Malodorous gray vaginal discharge, often with external irritation that usually includes itching or dysuria.
Transmission, Exposure	Person-to-person genital contact.
Incubation	Indeterminate.
Contagious Period	Indefinite in untreated persons.

Diagnosis	Usually made by noting the organism on microscopic examination of vaginal discharge.
Management of Case	Suspected cases should be referred for medical evaluation and treatment. Minors may seek care for sexually transmitted disease without parental knowledge or consent. Sexual contact should be avoided during period of infection and during treatment of patient and partner(s).
Management of Contacts	Sexual partners are usually asymptomatic, but they should be evaluated and treated in the case treatment is to be effective long-term.
Public Health Action	Promotion of "safer sex" behavior, including condom use, for all sexual contact is indicated.
School Action	• Provide preventive education with sex education curriculum. • Refer suspect cases for evaluation and appropriate treatment. • School exclusion is not appropriate. • Provide preventive education to include safer sex education.

Tuberculosis (TB) Screening Guidelines

As of July 30, 2004, transmission-free certification for tuberculosis (TB) is no longer a state-mandated requirement for employment in schools and daycare centers; therefore, TB testing is no longer required for new employees in schools and pre-schools.

New Mexico has been a low-incidence state for TB since 2000, which means that there are fewer than 3.5 TB cases per 100,000 persons. In the early 1990s, the American Thoracic Society, in conjunction with the CDC, encouraged TB testing only in individuals at high-risk for TB and discouraged all mandated pre-employment screenings. State TB programs were encouraged to take the lead in determining which groups should be screened based on local TB data. Testing low-risk individuals

often results in false positive tests and unnecessary treatment, diverting financial and human resources from other priorities.

Guidelines

- Tuberculin testing for employment in schools and daycare centers of low-risk individuals is ***not required*** in New Mexico.
- The NMDOH will offer testing/screening for close contacts to someone with active TB disease. Recent contacts (within the last two years) have increased risk for progression to active TB.
- For a full list of those qualifying for TB screening, contact your local public health office.

Primary Editors: *Miranda Durham, MD, New Mexico Department of Health & Karen Edge, MPH, New Mexico Department of Health*

Vicki Casias, BSN, RN School Health Advocate, NW Region & Kathryn Willits, RN Epidemiology Nurse, NW Region (on Molluscum)

Secondary Editors*: Rhonda Miranda, BS, RN, School Health Advocate, NW Region, New Mexico Department of Health & Jim Farmer, Director, Office of School and Adolescent Health, New Mexico Department of Health; Crista Pierce, BA, RN, CLNC, SW Regional School Health Advocate; Kate LaRose, BSN, RN, NE Regional School Health Advocate; Maricelda Pisana, BSN, RN, SE Regional School Health Advocate; Dr. Eugene Marciniak, MD, SW Regional Health Officer; Dr. Savanna Bustos, MD, NW Regional Health Officer; Dr. Christine Ross, MD, NE Regional Health Officer; Dr. Christopher Novak, MD, MPH, Medical Director*