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Introduction

This policy has been jointly produced by Barking and Havering Health Authority and BHB Community Health Care NHS Trust, in consultation with the London Boroughs of Barking & Dagenham and Havering. It replaces all previous documents issued on the subject of communicable diseases in schools, and is intended for the use of teachers, school nurses, general practitioners, practice nurses, health visitors, nursery and playgroup staff, childminders and local authority staff who work with children, e.g. in residential homes. The policy aims to promote a co-ordinated approach to the management of communicable diseases in the schools and nurseries of Barking, Dagenham and Havering.

The policy is intended as a general guide to the most common communicable diseases seen in children; it is not an exhaustive guide to communicable diseases. Whenever there is any doubt about the management of a communicable disease further advice is available from:

- the designated school nurse
- the child's GP, practice nurse or health visitor
- the Communicable Disease Team in the Public Health Department at Barking and Havering Health Authority, telephone 020 8532 6363

Children, who are unwell for any reason, including communicable diseases, should not be at school or nursery. Once they are better they should return to school/nursery unless they pose a risk to others. This policy gives guidance on some of the more common communicable diseases encountered in schools and nurseries and includes information on exclusion periods.

For many communicable diseases, outbreaks in schools/nurseries are actually a reflection of infection spreading in the general community and are difficult to prevent. However, it is important that an unexpected increase in cases of similar illness in a class at the same time is notified to the Public Health Department and that their advice is sought prior to advising parents as special control measures and guidance may be required.

Some communicable diseases can be passed on before a person becomes unwell. Others can be transmitted by apparently-well carriers of a disease. For these reasons it is important that high standards of basic hygiene and cleanliness are maintained at all times and not just in the event of an outbreak or during activities which are known to carry an increased risk. For example, after farm visits, hand-washing should be encouraged.

This policy is primarily intended to provide guidance on the management of children with communicable diseases. It should, however, be appreciated that when a member of staff contracts a communicable disease the same rules apply are likely to apply to them as to the children.

Immunisation schedule

Immunisation protects children and adults against illnesses which can be life threatening. Although immunisation uptake rates have been increasing, there are still children who do not receive this important protection. Often this is because of unfounded parental fears about safety or effectiveness. However, modern vaccines are **safe and effective** and every child should be fully immunised unless he/she has a genuine medical contraindication to a vaccination to which the GP agrees.

Vaccine	Age	Notes
Diphtheria/tetanus/pertussis and Hib, polio meningococcal type C	1st dose 2 months 2nd dose 3 months 3rd dose 4 months	Primary course
Measles/mumps/rubella (MMR)	12-15 months	Can be given at any age over 12 months
Booster diphtheria/tetanus and polio, MMR second dose	3-5 years	Three years after completion of primary course
BCG	10-14 years or infancy	
Booster tetanus/diphtheria and polio	13-18 years	

For holiday immunisation requirements please contact your GP well in advance of travelling.

Specialist immunisation advice is available from:

District Immunisation Co-ordinator
The Willows
St. George's Hospital
117 Suttons Lane
Hornchurch
Essex
RM12 6RS Telephone 01708 465495/465000

Exclusion from school

The following table is to be used in conjunction with the detailed information on the following pages. It is intended as an “exclusion at a glance” guide only. **Whilst in some cases exclusion is not necessary for communicable disease control purposes, do not accept a child into school if they are unwell e.g. fever, irritable, loss of concentration, nausea etc.** In cases of doubt contact the school/nursery nurse or GP for advice as appropriate.

Disease	Exclusion Period	Page
Acne	No exclusion necessary	14
Chickenpox	For five to seven days from onset of the rash, and when no new spots	15
Cold sores	Whilst sore and discharging, no exclusion necessary once healed	16
Conjunctivitis (sticky eye)	Exclude until better or improving on treatment from GP	17
Diarrhoea and vomiting	Exclude until diarrhoea and vomiting has stopped for at least 24 hours.	18
Eczema	No exclusion necessary unless infected	19
Febrile convulsions	Exclude until fever is settled and well	20
Fifth disease	Exclude until feeling well	22
Flu (influenza)	Exclude until feeling better and cough improved	23
Glandular fever	Exclude until feeling better	24
Hand foot and mouth disease	No exclusion necessary if well	25
Head lice	No exclusion necessary but refer to GP/ school/nursery nurse for advice if visible lice, as treatment is required as soon as possible.	26
Hepatitis A	For young children and those with poor hygiene, at least five days from onset of jaundice and when feeling better	27
Hepatitis B and C	No exclusion necessary, universal precautions for contact with blood or body substances	28
HIV/AIDS	No exclusion necessary, universal precautions for contact with blood or body substances	30

Disease	Exclusion Period	Page
Impaired immunity	In accordance with medical advice	31
Impetigo	Until healed	32
Measles	For five days after rash appears	33
Meningitis (not due to meningococcal infection)	None once better	34
Meningococcal disease	None once better	36
Molluscum contagiosum	No exclusion necessary	38
Mumps	For five days after swelling appears	39
Psoriasis	No exclusion necessary provided not infected	40
Ringworm (of the feet)	No exclusion necessary	41
Ringworm (of the scalp)	None once appropriate therapy started by GP	
Ringworm (other areas)	None once appropriate therapy started by GP	
Roseola	No exclusion necessary	42
Rubella (German measles)	Five days from onset of rash	43
Scabies	Until treated	44
Scarlet fever	Three days from starting antibiotics	45
Sore throat	None if mild viral type and well in self. Exclude if severe streptococcal type until improving and three days from start of antibiotic	46
Threadworm	No exclusion necessary, treatment is recommended	47
Pulmonary tuberculosis	Until two weeks after start of treatment. Seek advice from Consultant in Communicable Disease Control (CCDC)	48
Verrucae (warts)	No exclusion necessary, cover lesions	49
Whooping cough	Until five days from starting appropriate antibiotics	50

Outbreak control

- **Definition of an outbreak** - An unexpected increase in cases of a similar illness over a short time
- **Action** - If you suspect an outbreak, please contact the CCDC in the Public Health Department for advice on 020 8532 6363

Staff health

General

Adults should be fully immunised including BCG and hepatitis B. If they are unsure whether they are up to date with all their immunisations, they should consult their GP or occupational health provider.

Cuts on staff members' exposed skin must be covered with a waterproof dressing.

When a member of staff contracts a communicable disease the same rules apply to them as to the children. Sick staff should not be at work.

Pregnant staff

Chickenpox

This can affect the pregnancy of a woman who has not had the disease. If a pregnant woman is exposed early in pregnancy (the first 20 weeks) or the last three weeks she should promptly inform whoever is giving her ante-natal care to check she is immune by a blood test.

German measles (Rubella)

If a woman who is not immune to rubella is exposed to this infection in early pregnancy her baby can be damaged. Hence all female staff working in nurseries and schools should have their blood checked for rubella antibodies. Those who are not immune should arrange with their GP to have the rubella vaccine. If a woman who is pregnant and is unsure of her rubella immunity comes into contact with rubella she should inform her GP promptly.

Slapped cheek disease (Parvovirus)

Very rarely, parvovirus can affect an unborn child. If a woman is exposed in pregnancy she should promptly inform whoever is giving her antenatal care.

Good hygiene practices

Hand hygiene

Hand washing is the single most effective means of reducing cross infection. Its purpose is to remove or destroy any micro-organisms which have been picked up on the hands. Those causing disease are usually easy to remove with ordinary soap and water provided that all the areas of the hands are washed and dried thoroughly. In general, hand disinfectants are neither useful nor necessary.

Warm running water, liquid dispensed soap and disposable paper towels or hot air dryers are recommended. Roller towels are not desirable and if used should be changed at least daily.

Hand washing must be practised by everyone

- before meals
- after using the toilet (which, where necessary, should be supervised)
- when attending to any body fluids or other potentially infectious material

Because infections can often be passed on before a person is actually unwell, it is important that these basic hygiene practices are part of normal routine.

Environment

A regular programme of cleaning should be agreed and followed.

Thorough cleaning with hot water and detergent using disposable cloths, followed by adequate drying, will render the environment and items of equipment free of microorganisms likely to cause infection.

Disinfectants are not necessary for general environmental cleaning; they are expensive and can be toxic and resistance can develop.

Toilets and washbasins should be cleaned daily, and whenever there is visible soiling. A hypochlorite disinfectant (see next page) may be used for visible soiling during outbreaks of diarrhoea or vomiting.

Tanks of water used for play activities should be drained and cleaned regularly (at least weekly) and when visibly dirty.

Good hygiene practices (continued)

Dealing with blood and body fluids

Spillages should be dealt with promptly to avoid hazard to others.

1. Keep people away from the area
2. Wear latex gloves and a disposable apron
3. Soak up excess of spill with disposable towels
4. Cover spill with disposable towels
5. Apply sufficient 1% hypochlorite solution (Haztabs, Presept, Sanichlor or one part household bleach to ten parts water) for at least two minutes
6. Wipe up spill with hypochlorite soaked towels and discard into clinical waste sack in accordance with local policy
7. Wipe surface with general purpose detergent and hot water
8. Dispose of protective clothing
9. Wash hands

For spills on carpets and upholstery:

1. Wear latex gloves and disposable apron
2. Clear away excess with disposable paper towels and dispose of as clinical waste
3. Clean area with cold water
4. Clean area thoroughly with detergent and hot water
5. Allow to dry thoroughly.
6. Once dry, go over area with mechanical cleaner

Good hygiene practices (continued)

Sharps and splash injuries

These involve:

- Inoculation of blood by a needle or other sharp
- Contamination of broken skin with blood
- Blood splashes to mucous membrane, e.g. eyes or mouth
- Swallowing a person's blood, e.g. after mouth to mouth resuscitation
- Contamination where clothes have been soaked with blood

The following action should be taken:

1. Encourage bleeding from a skin wound
2. Wash the wound in soap and warm running water
3. Cover the wound
4. For splashes to skin, eyes or mouth: wash in plenty of running water
5. Ensure the sharp is disposed of safely
6. Ensure that a record of the accident is made
7. The person who sustained the wound should see their general practitioner or attend the Accident and Emergency Department as soon as possible. They should report with the name and address of the source patient, if known, and details such as whether the patient has source risk factors for blood-borne infection or has known infections or related disease.

Farm visits

It is important to remember that diseases affecting animals can sometimes be passed on to humans. Simple hygienic precautions, together with adequate preparation prior to, and supervision during, the visit will prevent this happening.

Preparation for the visit

- Check that the farm is well managed, that the grounds and public areas are as clean as possible and that there are suitable First Aid arrangements. Animals should be prohibited from any outdoor picnic areas.
- Check that the farm has suitable washing facilities, appropriately sign-posted, with running water (buckets of water are not acceptable), soap (preferably liquid) and disposable towels or hot air hand dryer(s). Any drinking water taps should be appropriately designated in a suitable area.
- Ensure that there is an adequate number of adults to supervise the children, taking into account the age and stage of development of the pupils.
- Explain to the pupils that they cannot be allowed to eat or drink anything, including crisps, sweets, chewing gum, etc. while touring the farm because of the risk of infection.
- Ensure suitable isolation and containment precautions are in place where appropriate, e.g. in restricted areas such as near slurry pits or where sick animals are isolated.

During the visit

- If children are in contact with or feeding farm animals, warn them not to place their faces against the animals or put their hands in their own mouths afterwards.
- After contact with animals and particularly before eating or drinking, ensure all pupils wash and dry their hands thoroughly. If young children are in the group, hand washing will need to be supervised.
- Meal-breaks or snacks should be taken well away from areas where animals are kept, and pupils warned not to eat anything which may have fallen on the ground. Any crops produced on the farm should be thoroughly washed in drinking water before consumption.
- Ensure pupils do not consume unpasteurised produce, for example milk or cheese, or taste animal feedstuffs, such as silage and concentrates.
- Manure or slurry presents a particular risk of infection, and pupils should be warned against touching it. If they do, ensure that they thoroughly wash and dry their hands immediately.

At the end of the visit

- Ensure all children wash their hands thoroughly before departure.
- Ensure footwear is as free as possible from faecal material.

Water based activities

Canoeing, sailing and other activities on fresh or coastal waters are enjoyable and to be encouraged. Parents and teachers are often worried about the risks of infections such as leptospirosis (Weils disease). This is acquired from freshwater contaminated by rats. The disease is very rare, especially the more serious forms, in spite of the large numbers of people who participate in water sports.

Some simple precautions will help to minimise the risks. Children who fall or swim in fresh water should shower and change their clothes promptly. Children should be discouraged from playing in obviously contaminated or very muddy waters.

Do's and Don'ts

✗Do not have contact with fresh water if there are cuts or abrasions on the skin

✗Do not swallow fresh water

Animals in school (permanently or visiting)

Animals may carry infections, especially gastro-enteritis, and guidelines for protecting the health and safety of children should be followed.

- Animal living quarters should be kept clean.
- All waste should be disposed of regularly.
- Litter boxes should not be accessible to children.
- Young children should not play with animals unsupervised.
- Children must wash their hands after handling animals, cleaning cages, etc.
- Particular care should be taken with reptiles as all species can carry salmonella.
- Do not clean animal cages or cage items in kitchen sinks or near food preparation areas
- Wash hands before eating or drinking and do not eat or drink whilst handling animals

Acne

Facts

- Acne is not transmissible between children.
- It is a chronic skin disorder.
- It affects adolescents and is sometimes severe.
- It affects predominantly the face, back and chest.
- There is a hard pimple, often with a blackhead on top, surrounded by pustules and inflammation.
- Scarring may occur in some severe cases.
- Exclusion: none.

Treatment

- Mild cases - daily washing of affected parts.
- Severe cases - a course of antibiotics may be prescribed.
- Natural sunlight is helpful.
- Usually disappears in early 20s.

Do's and Don'ts

- ✗ Don't squeeze the spots.

- ✗ Don't pick the spots.

Chickenpox

Facts

- Highly infectious virus spread by coughing, sneezing and direct contact.
- The child will develop cold symptoms followed quickly (less than 24 hours) by temperature and an itchy rash.
- Crops of blister-type spots will appear over a period of five days, particularly on the chest and back.
- Chickenpox can affect the pregnancy of a woman who has not had the disease. If a pregnant woman is exposed early in pregnancy (the first 20 weeks) or the last three weeks she should promptly inform whoever is giving her ante-natal care so her immunity can be checked
- Incubation period: two - three weeks.
- Period of communicability: from up to five days before rash appears to five to seven days after.
- Exclusion: for five to seven days after rash appears, and until no new spots appear and child is better.

Treatment

- Should be at home and includes controlling temperature and relieving itching.
- **Aspirin should never be used for temperature control in the under 12s.** Paracetamol should be used for this purpose.
- Complications are unusual but may include pneumonia, encephalitis and platelet disorders.

Do's and Don'ts

- ✓ Do send the child home from school.
- ✓ Do advise the parents to consult their GP.
- ✗ Don't allow child back to school until exclusion period is completed.

Long term aspects: the risk of shingles

- The chickenpox virus can lie dormant in spinal nerves after the primary infection. Reactivation of virus in children or adults results in shingles. Shingles is a painful, localised skin rash and it is potentially infectious. Exclusion from school is necessary until no more new vesicles are present and the rash is healing.

Cold sores

Facts

- Caused by a virus called herpes simplex.
- Generally appears on lips and around nostrils, but can spread more widely over the face.
- It is estimated that 50 - 90% of the population of this country are carriers of the virus, but they do not all suffer from cold sores.
- Caught by touching or kissing, or from sharing towels, cups or cutlery.
- Most people who already suffer from cold sores will have been infected very early in life.
- First signs are tingling, burning or itching in the area where it is going to appear. This phase may last for as little as 24 hours. There is reddening and swelling of the infected area resulting in a fluid filled blister, or sometimes a group of them, which can be very painful and uncomfortable. They break down to form ulcers, which weep and crack. They then dry up and crust over.
- The virus can be reactivated by various trigger factors such as stress, sunlight etc.
- If lesions are sore, weeping or discharging, exclude until healing.

Treatment

- Ask advice from your doctor or pharmacist.

Do's and Don'ts

- ✗ Don't touch the cold sore.
- ✗ Don't touch your eyes when you have a cold sore infection, and take extra care when applying or removing make-up.
- ✗ Don't kiss people, especially children, when you have a cold sore.
- ✗ Don't break the blisters or pick the scab on your cold sore.
- ✗ Don't share your eating or drinking utensils.
- ✗ Don't share towels or face cloths.
- ✓ Do wash your hands thoroughly if you accidentally touch a cold sore.

Conjunctivitis (sticky eye)

Facts

- Conjunctivitis is an inflamed and potentially infectious condition of the eye.
- Both eyes are usually affected.
- Symptoms include itching, a 'gritty' feeling (of the eye) and a sticky yellow or green pus discharge. The eye will look red and swollen.
- Exclusion: until better or improving on treatment from GP.

Treatment

- Careful cleansing, using separate cotton wool pads for each eye.
- Topical treatment prescribed by the GP.

Do's and Don'ts

- ✓ Do encourage parents to consult their GP.
- ✓ Do discourage children from rubbing their eyes.
- ✓ Do encourage the use of separate face flannels and towels.
- ✓ Do ensure that particular attention is paid to hand washing at all times.
- ✓ Do notify the Public Health Department in the event of an outbreak (two or more cases in a class).

Diarrhoea and vomiting

Facts

- It is a symptom in a variety of diseases and infections, is usually self-limiting and resolves spontaneously. Important to give fluid and electrolyte replacement.
- In a school situation it is usually due to a viral, bacterial or protozoal infection.
- In mild cases the cause is often not identified. If severe or prolonged symptoms then advise to visit GP who may give treatment and request a stool sample for testing to find the cause.
- May be infectious before symptoms develop.
- Good hand hygiene before eating and after toilet is likely to prevent spread.
- Exclusion: until 24 hours after the diarrhoea and/or vomiting has stopped except for children under 5, food handlers and children with learning disability, who should be excluded for 48 hours after the first normal stool.

Management where the cause has been identified

	Treatment
Viral	Advise to visit GP. Inform CCDC if two or more cases.
Giardiasis	Advise to visit GP for specific treatment
Salmonella/campylobacter	Seek advice from GP if the child is unwell. Inform CCDC if two or more cases
Shigella	Seek advice from GP if the child is unwell. Inform CCDC if two or more cases
E coli and haemorrhagic uraemic syndrome	Seek advice from GP if unwell. Notify CCDC of every case

Do's and Don'ts

- ✓ Do encourage staff and children to practice good hand hygiene at all times.
- ✓ Do notify the Consultant in Communicable Disease Control if there are more cases than normally expected.

Eczema

Facts

- Eczema is a skin disorder, often associated with asthma or hay fever.
- It is recurrent, usually provoked by allergies or contact with certain substances.
- It is commonly found in the skin creases around joints but may also affect large areas of the body.
- The skin becomes dry, red and intensely itchy and may become 'weepy' or bleed.
- Broken skin is prone to infection.
- Areas of skin previously affected by eczema often have a pigmented 'dirty' appearance.
- Eczema is not catching, but may be inherited.
- Exclusion: none unless infected.

Do's and Don'ts

- ✓ Do be aware that eczematous children often feel outcast because of their appearance. Do not restrict activities such as swimming on grounds that the child is infectious unless there is specific medical advice to the contrary. Ask parents whether or not the child is able to join in on that particular day.
- ✗ Don't be afraid to touch the child - eczema is not catching.
- ✓ Do make allowances for impaired concentration with a child constantly irritated by eczema.
- ✓ Do try to distract children when they scratch, as it will make the eczema become sore and increase the possibility of infection.
- ✓ Do allow the children to know their own limitations regarding PE if they have cracked and painful skin.
- ✓ Do contact the school nurse for advice on specific management problems.

Long term aspects

- Eczema can come and go over a period of years. Many children improve spontaneously as they grow older. Employment prospects are only likely to be affected if working with specific allergens or substances that irritate their skin.

Useful Address: The National Eczema Society, Tavistock House North, Tavistock Square, London WC1H 9SR Telephone: 0171 388 4097

They have videos suitable for use in schools.

Febrile convulsion

Facts

- A febrile convulsion should not be confused with epilepsy, although the symptoms are the same.
- A febrile convulsion is a seizure precipitated by a rise in body temperature. It rarely develops into epilepsy and will spontaneously remit without specific therapy.
- The febrile convulsion may signify a serious underlying acute infectious disease and therefore the child must be seen by a doctor to investigate the cause of the fever.
- There are many causes of fever, varying from ear infection, tonsillitis, urinary infection, infectious disease and meningitis etc.
- The febrile seizure occurs within hours of the onset of fever, usually when the temperature is 39°C or over. The seizure is typically generalised, tonic clonic of a few seconds to 10 minutes duration followed by drowsiness.
- Febrile convulsions are more common in children under seven years of age.
- Children who have had a febrile convulsion are 30% more likely to have a recurrence. They are at no greater risk for intellectual or growth abnormalities than their peers. A tendency towards having febrile convulsions appears to be inherited.
- Exclude until fever has settled and child is better.

Treatment

- Initial management of a seizure is the same as for epilepsy - see the following section.
- An ambulance should be called and the child taken to the accident and emergency department. Parents should be informed as soon as possible.

Do's and Don'ts

- ✓ Do call an ambulance in the event of a febrile convulsion.
- ✓ Do keep the child cool whilst waiting for parents or ambulance.
- ✓ If unconscious or drowsy, do place in recovery position.

Management of seizures

What to do if someone has a seizure

A major seizure may appear dramatic and frightening to an observer, but the person affected normally feels no pain during the seizure. It is important to keep calm - you cannot stop the seizure - let it run its course. Only a few simple measures are necessary to ensure the person's safety.

When the seizure starts

- Note the time.
- Clear a space around the person, moving objects which may be harmful.
- Reassure others and explain what you are doing.
- Make the person comfortable lying down, easing from a chair only if necessary.
- Cushion the head to prevent facial injury.
- Loosen tight neckwear. Remove spectacles and high-heeled shoes, if worn.

When the movements have stopped

- Turn the person on to their side (first aid recovery position).
- Wipe away any excess saliva from the mouth; check that vomit or dentures are not blocking the throat.
- Some people have seizures which put them temporarily into a state of altered consciousness. Behaviour may seem inappropriate, e.g. they may wander around purposelessly with a glazed expression. During this type of seizure the person should be accompanied and gently led away from any source of danger.

At the end of the seizure

- **Reassure** if the person seems confused and tell them what happened.
- **Check for obvious injury** and apply first aid if necessary.
- **Observe and stay with the person** until the recovery is complete. They may need assistance to return to their routine or find their way home. Provide privacy and offer assistance if there has been incontinence.

Do's and Don'ts

- ✗ Don't put anything in the mouth.
- ✗ Don't restrain or restrict movements during the seizure.
- ✗ Don't give anything to drink.
- ✗ Don't move unless in danger.

Fifth disease (slapped cheek disease)

Facts

- It is an infectious disease of children caused by a virus which is spread by coughing and sneezing.
- It results in a rash on the face, on one side or both, which looks like a slap mark on the cheek - hence the name.
- It is a common disease that is also called erythema infectiosum, which means an infectious rash.
- It occurs in small outbreaks.
- The child is only slightly unwell and the rash spreads over the body and then fades. Some children may get joint pains but this is unusual. The rash may come back on and off for several weeks.
- Very rarely, the slapped cheek virus can affect an unborn child. If a woman is exposed early in pregnancy (before 20 weeks), she should promptly inform whoever is giving her antenatal care.
- Incubation period: 4 - 14 days
- Period of communicability: greatest before onset of rash
- Exclusion: It is not necessary, unless the child is unwell, as once the rash starts they are not generally infectious.

Treatment

- Treatment consists of pain and temperature control although this is very rarely required. No other treatment is required as it will get better by itself. There are no serious side effects or complications unless infection occurs in the first 20 weeks of pregnancy, when it can cause foetal problems or if the patient has a haemolytic anaemia (e.g. sickle cell anaemia), when the anaemia can be made worse and the infection be prolonged. However, in most cases there is only a mild illness.

Do's and Don'ts

- ✓ Do advise a visit to the GP.
- ✓ Do request that parents inform the school of a diagnosis of fifth disease.

Flu (influenza)

Facts

- It is caused by a virus and is more common in the winter months (November to March).
- It is a sudden onset with fever, cough, headache, and muscular pain.
- Usually self-limiting, unless there is secondary bacterial infection.
- Incubation period: 1 – 3 days.
- Period of communicability: maximum infectivity occurs prior to and at the onset of symptoms.
- Exclusion: None, provided child is well enough to return, i.e. no fever, earache or cough.

Treatment

- Consists of temperature control and giving plenty of fluids.
- **Aspirin should never be used for temperature control in the under 12s,** paracetamol should be used for this purpose.

Transmission

- Airborne spread from other human beings who carry the virus in their throat.

Do's and Don'ts

- ✓ Do encourage parents to seek advice from the GP.
- ✓ Do educate children about unprotected coughing.
- ✓ Do advise immunisation for children at risk, i.e. those with chronic respiratory disease including asthma, chronic heart disease, chronic kidney disease, diabetes or whose defences (immune systems) are weak due to chronic illness.
- ✗ Don't confuse flu with the common cold.

Glandular fever (infectious mononucleosis)

Facts

- Glandular fever is an acute viral disease caused by a specific virus.
- Symptoms include fever, sore throat and enlarged lymph glands. About half of all cases have an enlarged spleen whilst a small number of cases are jaundiced.
- Duration is from one week to several months.
- In young children the disease is generally mild.
- The disease is most frequently seen in older childhood and early adulthood.
- Glandular fever is not easily spread, but transmission can occur from person to person by saliva, although spread on toys and hands, for example, can occur. Kissing facilitates spread among young adults.
- Incubation period: 4 - 6 weeks.
- Period of communicability may be prolonged. The virus may be present in saliva for a year or more after infection.
- Exclusion: none, once child is feeling better and no fever.

Treatment

- Generally consists of rest and supportive measures. Encourage parents to seek advice from the GP.

Do's and Don'ts

- ✓ Do ensure that particular attention is paid to hand washing at all times.
- ✓ Do ensure that items soiled by oral secretions are disposed of or washed straight away.
- ✗ Don't forget that the child could be under par for some months.

Long term aspects

- Usually self-limiting.

Hand foot and mouth disease

Facts

- It is an acute, self-limiting viral disease. It is spread by direct contact with nose and throat discharges, by coughing and sneezing or direct contact with the faeces of infected persons. It frequently occurs in outbreaks among groups of children especially in nursery schools.
- Small greying blister-like lesions appear in the mouth and may also occur on the palms, fingers and soles.
- Incubation period: three - five days.
- Period of communicability: throughout acute stage of illness (normally no longer than 10 days) perhaps longer as these viruses persist in faeces for several weeks.
- Exclusion: none if feeling well.

Treatment

- Encourage parents to seek advice from their GP.

Do's and Don'ts

- ✓ Do pay particular attention to the possible spread by faecal material.
- ✓ Do ensure that any articles soiled by nose and throat discharges, or by faeces are disposed of or washed straight away.
- ✓ Do ensure that particular attention is paid to hand washing at all times.
- ✗ Don't confuse with foot and mouth disease in animals.

Long term aspects

- Usually self-limiting.

Head lice

Facts

- Head lice rarely cause physical health problems other than itching of the scalp and occasional secondary bacterial infection of bites.
- Head lice are small insects, which live in the hair very close to the scalp. These pictures of lice are actual size * * * * * - the largest is a mature adult.
- The female lays eggs at the base of a hair which hatch in about seven days leaving the empty eggshell, or nit, firmly attached to the hair.
- Head lice are not primarily a problem of schools but of the wider community.
- A definitive diagnosis of head lice infection cannot be made without the identification of a live moving louse. The most effective method of detecting a live moving louse is through wet detection combing.
- Contact tracing of those who have had close prolonged head to head contact with an infected person is of paramount importance in the control of head lice.
- Donors of head lice can be of any age and are often without symptoms.
- Period of communicability: until treated.
- Exclusion: None, unless a child has visible lice and/or infected skin when parents can be referred to the school/nursery nurse and GP for advice on treatment and preventive measures.
- If two or more cases occur in a class, inform the school nurse who may contact the CCDC in Public Health for advice.

Treatment

- Treatment is only necessary for those who are infected with head lice. If detection combing fails to reveal a live moving louse, no treatment should be given.
- Treatment is achieved by using a chemical insecticide or the wet combing method or a combination of the two.
- When using a chemical insecticide, **one treatment equals two applications** one week apart.
- Treatments such as essential oils, vinegar and electronic combs are not recommended.

Hepatitis A

Facts

- Virus spread by faecal-oral contamination of contaminated food and water or raw sewage.
- Symptoms include fever, headache, loss of appetite, nausea, vomiting and abdominal pain.
- Jaundice is common (but children do not always develop this sign).
- Dark urine and pale stools are also common.
- Recovery usually occurs after the jaundice and dark urine appear, but return of appetite and energy may take two weeks.
- Incubation period: 15 - 50 days
- Period of communicability: infectivity is highest during the second half of the incubation period.
- Exclusion: for young children and those unlikely to practise good hand hygiene, exclude for five days after the onset of jaundice or pale stools and until feeling better.

Treatment

- Is usually by rest at home and by seeking advice from GP for control of symptoms.
- Recovery is usually complete.

Do's and Don'ts

- ✓ Do encourage staff to use good hygiene practices **at all times** (not just in suspected cases of hepatitis)
- ✗ Do take care to wash hands before handling food and after going to the toilet.
Maintain cleanliness of kitchen and toilet surfaces
- ✗ Do handle blood/body substances with universal precautions as is usual, due to the unknown risk
- ✗ Don't confuse hepatitis A with hepatitis B or C
- ✓ Do advise household contacts to contact GP as immunisation may be indicated

Hepatitis B and C

Facts

- These viruses are spread by the exposure of a susceptible uninfected person to infected blood, blood products or body substances. The means by which infection is transmitted includes the sharing of needles by intravenous drug users, unprotected sexual activity and failure to implement the recommended infection control measures, including universal precautions.

Hepatitis B

- Up to 10% of adults and more than 90% of babies infected fail to clear the virus and become carriers
- Infection can be fatal in a small number of cases. However in most cases symptoms are mild, e.g. loss of appetite, malaise, nausea, flu-like symptoms, joint pains and a rash. Jaundice sometimes develops (but less commonly in children).
- Diagnosis is confirmed by blood tests.
- Incubation period: 45 - 90 days, but can be up to 6 months.
- Exclusion period: none once recovered and well.
- Protective hepatitis B vaccination: GP will offer hepatitis B immunisation to close household or kissing contacts. It may be indicated for staff and children in residential schools/nurseries for learning disability

Hepatitis C

- Up to 80% of those who have had the disease may continue to carry the virus.
- Acute infection is mild with many patients often unaware of the infection. Most patients complain of fatigue but few have jaundice. Chronic effects can take two or three decades to appear.
- Diagnosis is confirmed by blood tests.
- Incubation period: 1 - 26 weeks.
- Exclusion period: none once recovered and well.

Treatment

- Is usually by rest at home and GP advice on control of symptoms. Hospitalisation is sometimes necessary. An asymptomatic carrier state may persist after signs of acute illness have settled.

Hepatitis B and C (continued)

Do's and Don'ts

- ✓ Do encourage staff and children to practice good hygiene at all times.
- ✓ Do insist that staff **wear disposable gloves when handling any blood or body substances and wash hands after contact = universal precautions.**
- ✓ Do ensure that gloves and soiled matter are disposed of in sealed, leakproof bags adequately and safely.
- ✓ Do ensure that spills of body fluids are cleaned up with disposable towels and appropriate disinfectants, e.g. Milton, Presept, Haztabs, Sanichlor.
- ✓ Do ensure that children avoid contact with body substances of other children and wash hands if contact occurs
- ✓ Do cover cuts or discharging skin lesions with waterproof plasters
- ✗ Don't pick up discarded syringes and needles without precautions.
- ✗ Never recap needles
- ✓ Dispose of sharps with minimum handling in sharp proof containers.
- ✗ If a sharp injury occurs with potential exposure to blood/body substances of another person, then report to the GP or AED as soon as possible so that a risk assessment can be made and treatment or immunisation offered if appropriate.

NB Most hepatitis B and C carriers will be unknown. Safe practices must be used for **all** children at **all times**. Take universal infection control precautions to minimise risk

HIV and AIDS

(Human Immuno Deficiency Virus and Acquired Immune Deficiency Syndrome)

Facts

- Infection with HIV may lead, after a period of months or years, to AIDS. AIDS is a serious disease that reduces the body's ability to fight infection. Anyone can get HIV/AIDS: young or old, male or female, 'gay' or 'straight'.

Transmission

- Spread of HIV is by exposure to blood or body substances of an infected person e.g.
 - ⇒ through sexual intercourse, (vaginal, anal or oral) with an high-risk person such as: sex worker, bi/homosexual male or a person who has many partners
 - ⇒ by sharing needles during intravenous drug misuse.
 - ⇒ from an infected mother to baby before, during or after birth.
 - ⇒ through blood or blood products during a transfusion. This is very unlikely today because all blood and blood products are tested before use.
 - ⇒ by any device which may be contaminated with blood, and which punctures the skin, including tattooing and acupuncture needles, equipment for ear piercing or electrolytic removal of hair and barbers' razors.
- HIV is **not** spread through casual or social contact or through the air or by donating blood
- Exclusion: discuss with CCDC. Exclusion is not usually required if there are no symptoms.

Do's & Don'ts (also see under hepatitis B and C)

- ✓ Do encourage staff and children to practice good hygiene at all times.
- ✓ Do take universal precautions for all contact with blood/body substances
- ✓ Do inform potentially 'at risk' individuals to say 'no' to drugs.
- ✓ Do inform that sharing needles for injecting drugs just once can transmit the viruses for life.
- ✓ Do inform, where appropriate, to say 'no' to at risk sexual behaviour as the infection can spread by sexual activity particularly in high-risk groups.

Note

Most people infected with HIV will be unknown. Therefore, to prevent potential spread of infection it is important to take universal infection control precautions for all

possible or actual contact with blood or body substances from anyone. Avoid at risk behaviour.

Impaired immunity

Facts

- Some children have medical conditions that make them especially vulnerable to infections that would rarely be serious in most children.
- Examples of vulnerable children are:
 - ⇒ those being treated for leukaemia
 - ⇒ those being treated for other cancers
 - ⇒ children on high doses of steroids
 - ⇒ those with other conditions which seriously impair immunity.
These children are especially vulnerable to communicable diseases such as chicken pox and measles.
- Some children with severely impaired immunity may need to have their drinking water boiled to avoid the risk of cryptosporidium infection

Do's and Don'ts

- ✓ Do encourage parents to notify the school of impaired immunity in their child.
- ✓ Do inform the schools nurse if she is not already aware of the child.
- ✓ Do advise the parents of any known exposure of the child to communicable diseases whilst at school. They can seek advice on preventive action from the GP or hospital doctor, if appropriate.

Impetigo

Facts

- It is an infectious skin disease caused by bacteria.
- It is often found in school children.
- It consists of vesicles which appear particularly on the face and which dry up leaving a yellowish-brown scab from which the discharge is infectious. The scabs fall off, leaving no scars, but the disease spreads from place to place over the skin and may last for months if untreated.
- Period of communicability: whilst discharging new lesions
- Exclusion: until no discharge and healing. Seek antibiotic treatment from GP

Treatment

- Advise parents to seek advice from their GP as antibiotics may be required to prevent spread and speed healing.

Do's and Don'ts

- ✓ Do keep the child off school until lesions are healing.
- ✓ Do encourage cleanliness and good hand hygiene in the family and at school.
- ✗ Don't share washing and eating utensils.
- ✗ Don't pick the scabs.

Long term aspects

- Once treated it clears well.

Measles

Facts

- Measles is a highly infectious virus spread by direct contact with nasal and throat secretions and by coughing and sneezing.
- At least 90% of children are immunised and protected; therefore it occurs in unimmunised children.
- The child usually develops a runny nose followed by conjunctivitis, cough and inflamed tonsils. Small white spots (koplik spots) appear inside the cheeks.
- After two to three days a temperature develops followed after four to seven days by a red blotchy rash which starts behind the ears and spreads over the face and body.
- In rare cases measles can be fatal.
- There are other conditions that can mimic the symptoms of measles.
- Incubation period: 7 - 18 days.
- Period of communicability: from onset of symptoms to five days after rash appears.
- Exclusion: for five days from onset of rash and well

Treatment

- Consists of temperature control and tender loving care!
- Some children may become sensitive to light, because of conjunctivitis, and want the curtains drawn. Complications include encephalitis, pneumonia, croup, otitis media and occasionally convulsions. Hospitalisation may be necessary in these cases.

Do's and Don'ts

- ✓ Do encourage staff and children to practice good hygiene at all times.
- ✓ Do advise the parents to take a sick child to the GP.
- ✓ Do encourage parents to have their children immunised against measles.

Meningitis

(not due to meningococcal disease)

Facts

- Meningitis not due to meningococcal infection can be caused by both bacteria and viruses.
- Exclusion: No exclusion is required once the child is well enough to attend school.
- Discuss the need for contact tracing with the CCDC

Bacterial

- Haemophilus influenzae type b (Hib) meningitis is one form of bacterial meningitis but since the introduction of the Hib vaccine into the routine immunisation programme in October 1992 the incidence of cases has decreased dramatically. Very few cases occur, as this type of meningitis is now rare.
- Pneumococcal meningitis is another form of bacterial meningitis.

Viral

- Meningitis caused by viruses is more common than bacterial meningitis. It is rarely life threatening but it can make people very weak.
- Viral meningitis can be caused by many different viruses – some are spread by coughing and sneezing, or through poor hygiene, and others can be found in sewage polluted water.
- The illness is characterised by a sudden onset of fever, headache, vomiting, dislike of light, confusion, drowsiness, unconsciousness

Treatment

- All causes of bacterial meningitis can be treated with appropriate antibiotics, so this treatment should be started urgently on suspicion of meningitis, even though hospital test results may establish another cause eventually.

Do's and Don'ts

- ✓ Do take an extremely ill child to AED for urgent assessment. Otherwise, do advise the parents to consult their GP urgently.
- ✓ **Don't delay** in seeking medical attention if meningitis is suspected, it can be life threatening and needs treatment urgently.
- ✓ Do inform the school nurse of any cases of meningitis.

Meningitis **(not due to meningococcal disease)** **continued**

Long term aspects

- Children normally make a good recovery from viral meningitis.
- Bacterial meningitis can be more severe but most children fully recover in time and hearing checks are normally carried out.

Useful Addresses:

<p>Meningitis Research Foundation Midland Way Thornbury Bristol BS35 2BS ☎ 24 hour helpline 080 8800 3344 e-mail info @ meningitis.org www.meningitis.org</p>	<p>National Meningitis Trust Fern House Bath Road Stroud Gloucestershire GL5 3TJ ☎ 24 hour help line 0845 6000 800 e-mail.support @ meningitis-trust.org.uk</p>
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Meningococcal disease

Facts

- The course of meningococcal disease can be very rapid (sometimes within a matter of hours). Urgent medical assistance should be obtained for any child with rapidly declining health, irrespective of symptoms.

Meningococcal meningitis

- Meningococcal meningitis (caused by the bacterium *Neisseria meningitidis*) is the most common bacterial form in the UK, accounting for more than half the cases of meningitis. There are several different groups. Group B is the most common, followed by group C. Group A is rare in this country.
- The bacteria which cause meningococcal meningitis are common and live naturally in the back of the nose and throat, or the upper respiratory tract, in approximately 10 to 25% of the population at any one time. These individuals are defined as carriers.
- People of any age can carry the bacteria for days, weeks or months without becoming ill. Only rarely do the bacteria overcome the body's defences and cause meningitis.
- The bacteria are spread between people by coughing, kissing and sneezing during prolonged contact.
- The bacteria cannot live for long outside the body so they cannot be picked up from water supplies, swimming pools or buildings.
- Anyone, anywhere can contract meningitis, but those most at risk are children under five, teenagers, young adults and older people.
- Most cases are isolated and **not** related to another case.
- Symptoms of meningococcal meningitis include, but not all are always present, a red pin prick rash, which may not blanch, fever/vomiting, drowsiness, severe headache, stiff neck and dislike of bright lights.
- The incubation period is between two and seven days.

Meningococcal septicaemia

- The bacteria which cause meningococcal meningitis can also cause septicaemia (blood poisoning).
- Symptoms of meningococcal septicaemia include a combination of a red pin prick rash which does not fade on pressure and which can develop into purple bruises, fever, vomiting, cold hands and feet, rapid breathing, stomach/joint/muscle pain and drowsiness.
- Septicaemia can occur with or without meningitis.

Meningococcal disease (continued)

Treatment

- Urgent treatment in hospital with antibiotics is essential for cases of meningococcal meningitis or septicaemia. The sooner someone with meningitis is diagnosed and treated, the greater chance there is that they will make a full recovery.
- Meningococcal meningitis is not highly infectious so only the patient's close household or kissing contacts are at a slightly increased risk of becoming ill and will need to receive information and antibiotics.
- Other contacts, like school friends or colleagues, have had less exposure and so are not at higher risk. However, they will be informed to be alert to the symptoms and to act if the illness is suspected. They do not normally need to receive treatment or be excluded from school unless advised by the Public Health Department.

Do's and Don'ts

- ✓ Do contact the child's parents immediately, and in any event ensure that the child is taken to the nearest Accident & Emergency Department **urgently**.
- ✓ Do liaise with the CCDC about follow up of contacts and for guidance on letters to parents.
- ✓ Do inform the CCDC if two or more cases occur in a four week period.
- ✓ Do inform the Public Health Department, Education Department and School Nurse.
- ✓ Do refer worried parents to the helpline numbers below for guidance and information leaflets

Long term aspects

- The majority of those affected will make a full recovery, but a minority may have residual damage and fatalities can rarely occur.

Useful Addresses:

Meningitis Research Foundation Midland Way Thornbury Bristol BS35 2BS ☎ 24 hour helpline 080 8800 3344 e-mail info @ meningitis.org www.meningitis.org	National Meningitis Trust Fern House Bath Road Stroud Gloucestershire GL5 3TJ ☎ 24 hour help line 0845 6000 800 e-mail.support @ meningitis-trust.org.uk
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Molluscum contagiosum

Facts

- Molluscum contagiosum is a benign self-limiting disease caused by an unclassified pox virus. The infection is common in infants and children.
- Lesions may be single but are usually multiple and appear as discrete raised pearly papules with a central dip. Occasionally giant solitary lesions occur.
- Lesions can occur anywhere on the body.
- Individuals with contact dermatitis are more prone to develop spreading lesions.
- Infection is spread by close skin to skin contact and lasts for many months (6 months to two years).
- Incubation period: two - seven weeks.
- Exclusion: none.

Treatment

- Resolution of lesions occurs usually within one year without treatment. Alternative treatments are available from the GP.

Do's and Don'ts

- ✓ Do encourage parents to take child to GP.
- ✗ Don't scratch spots.
- ✓ Do avoid direct skin to skin contact with infected areas.
- ✗ Don't pick spots.
- ✓ Do use separate washing and eating utensils if papules are on the hands or face (although this is unusual).

Mumps

Facts

- Mumps is a highly infectious virus spread by coughing and sneezing and by direct contact with the saliva of an infected person.
- Symptoms include headache, temperature and general malaise followed by painful swelling of the glands under the jaw, on one or both sides of the face.
- Following MMR immunisation the incidence of mumps has reduced considerably.
- Incubation period: 16 - 20 days.
- Period of communicability: from 6 days before swelling to four days after it appears.
- Exclusion: for five days after the onset of swollen glands.

Treatment

- Should be at home.
- Consists of pain relief and temperature control. Complications can be severe and include meningo-encephalitis and pancreatitis, when hospitalisation may be necessary. In adult/adolescent men mumps may cause a painful swelling of the testicles and (rarely) cause sterility. Deafness or hearing impairment may occur.

Do's and Don'ts

- ✓ Do encourage staff and children to practice good hygiene at all times.
- ✓ Do send the child home if unwell.
- ✓ Do advise the parents to see their GP.
- ✓ Do encourage parent to have their children immunised against mumps.

Psoriasis

Facts

- Psoriasis is not an infectious disease. There may be a family history.
- It is a disease of the skin in which raised, rough, reddened areas appear, covered with fine silvery scale.
- The nails are involved in about 50% of cases.
- Generally appears in adolescence or early adult life.
- Eruption appears usually round the back of the elbows and the front of the knees.
- Begins as small pimples, each covered with white cap of scales which enlarge. At the same time patches appear on other parts of the body - trunk, back, limbs, scalp and sometimes the face.
- Exclusion: none unless infected

Treatment

- Treatment aims to control symptoms.
- Attend to general health.
- Alleviate anxiety as this leads to an improvement in the condition.
- Important for person to be well motivated as success largely depends on willingness to apply what are often messy creams several times a day for long periods.
- Many types of cream are used and natural sunlight or ultraviolet light helps.

Do's and Don'ts

- ✗ Don't scratch the lesions.
- ✓ Do keep nails short and clean.

Long Term Aspects

- Secondary infection of lesions can occur.

Useful Address

Psoriasis Association, 7 Milton Street, Northampton NN5 7JG.
Telephone: 01604 711129

Ringworm

Facts

- Sometimes called tinea.
- It is an infection of the skin caused by a fungus.
- There are varieties caught from animals, but it is most often passed from one person to another.
- On the body it usually produces circular rashes which spread in ever enlarging circles while healing in the centre. The edge is the active growing area of the rash.
- Exclusion (athlete's foot): none
- Exclusion (skin): none once the GP has initiated appropriate treatment.
- Exclusion (scalp): none once the GP has initiated appropriate treatment.

Treatment

- Ringworm of the foot (athlete's foot) is potentially infectious to others from contaminated surfaces. Careful hygiene is needed. To prevent further spread, wash and dry the affected skin using personal towels and use anti-fungal treatments.
- Ringworm of skin - antifungal cream.
- Ringworm of the scalp - a special antibiotic taken by mouth.

Do's and Don'ts

- ✓ Do wash and dry feet well in cases of athlete's foot.
- ✓ Do keep towels separate in all cases.
- ✓ Do ensure the child with ringworm of the feet is wearing socks and plimsolls. No exclusion is needed provided the child has been treated and/or his/her feet are covered for PE.

Long Term Aspects

- There is a risk of secondary bacterial infection of the lesions.
- Do ensure that visible patches of ringworm, e.g. on hands and faces, are covered by a dry dressing.

Roseola

Facts

- Roseola is an acute illness caused by a virus.
- It is usually seen in the under four age group but is most common in two year-olds
- It is spread by direct contact with nose and throat discharges and by coughing and sneezing.
- The child develops a fever (sometimes as high as 41⁰ C) which lasts for three to five days.
- As the fever subsides a rash appears on the trunk and spreads to the rest of the body but not the face. The rash usually fades quickly.
- Symptoms are generally mild, but febrile convulsions have been reported.
- Incidence is greatest in the spring.
- Incubation period: about 10 days.
- Exclusion: None, unless well.

Do's and Don'ts

- ✓ Do make sure you know how to manage a febrile convulsion (see pages 20 and 21).
- ✓ Do ensure that any articles soiled by nose and throat discharges are disposed of or washed straight away.
- ✓ Do ensure that particular attention is paid to hand washing at all times.

Rubella (German measles)

Facts

- Rubella is an infectious virus spread by coughing and sneezing and by direct contact with nasal and throat discharges.
- The child may complain of sore throat, cough and have a runny nose. The glands at the back of the neck may be enlarged. A fine pink rash appears on the face and spreads to the rest of the body over 24 hours. Rubella is often difficult to diagnose. It can be mild and it is similar to other viral infections.
- Following the introduction of MMR immunisation the incidence of rubella has reduced considerably.
- If a woman who is not immune to rubella is exposed to this infection in early pregnancy her baby can be damaged. Hence all female staff working in nurseries and schools should have their blood checked for rubella antibodies. Those who are not immune should arrange with their GP to have the rubella vaccine. If a woman who is pregnant is unsure of her rubella immunity and comes into contact with rubella she should inform her GP promptly.
- Incubation period: 14 - 23 days
- Period of communicability: from seven days before rash to five days after it appears.
- Exclusion: for five days from onset of rash.

Treatment

- Should be at home and consists of controlling symptoms. Complications are rare, but include encephalitis and joint pains.
- Rubella in childhood is a mild self-limiting illness. However if a pregnant woman is infected severe defects may occur in the unborn child.

Do's and Don'ts

- ✓ Do encourage staff and children to practice good hygiene at all times.
- ✓ Do advise the parents to see their GP.
- ✓ Do inform other parents so that individuals who could be pregnant, and who may have been in contact with a case, can seek medical advice.
- ✓ Do advise staff members who are pregnant to seek medical advice.
- ✓ Do encourage parents to have their children immunised against rubella (MMR vaccine).

Scabies

Facts

- Caused by a tiny mite which burrows into the skin.
- Scabies is spread by prolonged skin to skin contact.
- The mites cannot jump or fly.
- Scabies is not spread by towels, bedding or clothing.
- Scabies causes itching which is often worse at night. Scratching can lead to secondary bacterial infections of the skin.
- Outbreaks occasionally occur in schools and nurseries.
- Incubation period: two to six weeks.
- Period of communicability: until properly treated.
- Exclusion: the child can return as soon as properly treated.

Treatment

- Treatment is achieved by the use of a chemical insecticide which is applied to the skin.
- All members of the household should be treated as the symptoms of scabies can take several weeks to appear, during which time close contacts may be infected.

Do's and Don'ts

- ✓ Do advise a visit to the GP
- ✓ Do be aware that the itch associated with scabies can persist for some weeks after the successful eradication of the infection and it is due to an allergic reaction, not infection.

Scarlet fever

Facts

- It is a disease characterised by a skin rash which appears most often on the neck, chest, underarms, elbows, groin and inner surfaces of the thighs.
- It is usually better felt (like sandpaper) than seen.
- The rash does not often affect the face but flushing of the cheeks is not uncommon.
- In severe infection, other symptoms may include high fever, nausea and vomiting.
- Scarlet fever is spread by coughing and sneezing or direct contact with infected individuals.
- Incubation period: one to three days.
- Period of communicability: 10 - 21 days.
- Exclusion: Until better and for at least three days after start of antibiotic treatment.

Treatment

- Parents should seek advice from their GP.

Do's and Don'ts

- ✓ Do ensure that particular attention is paid to hand washing at all times.
- ✓ Do send the child home from school if unwell.
- ✓ Do advise parents to take the child to their GP.

Long term aspects

- Second attacks of scarlet fever are rare.

Sore throat

Facts

- Sore throats are very common and occur particularly in winter months.
- They are usually caused by an infection which affects the back of the throat (pharyngitis) and/or the tonsils (tonsillitis).
- Sore throats are usually caused by viruses and accompany a cold or flu but, occasionally, bacteria such as streptococcus can cause sore throats. Streptococcal sore throats cause the most severe side effects.
- Symptoms of sore throats may vary from a mild soreness on swallowing to severe pain and difficulty in swallowing. Other symptoms may include a fever and swollen neck glands.
- Exclusion: none if the child is otherwise well and a mild viral infection is likely but exclude if feverish and unwell until better. If streptococcal tonsillitis is diagnosed by GP, exclude for at least three days from start of antibiotic treatment.

Treatment

- The majority of sore throats should clear up in three to four days.
- Increased fluid intake and simple painkillers are recommended.
- If symptoms do not improve after a few days then the GP should be consulted. Antibiotics may be recommended if the sore throat is bacterial.

Do's and Don'ts

- ✓ Do ensure that the child has plenty to drink.
- ✓ Do encourage the parents to visit the GP if the symptoms persist.

Threadworm (pinworm)

Facts

- Symptoms include itching around the bottom, disturbed sleep, irritability and sometimes secondary bacterial infections.
- In cases of doubt threadworms are accurately diagnosed with a simple test from the GP. A piece of sellotape 2.5 by 7.5 cm is placed sticky side down around the anus immediately on waking. It is then transferred to a microscope slide, again sticky side down, and sent for examination in a laboratory. The worm's eggs are easily seen in this way. Sticky tape examination should be repeated three or more times before accepting a negative result.
- Transmission occurs by direct transfer of infective eggs from anus to mouth of the same or another person. Eggs hatch in the small intestine of the host and mature as they pass through the small and large intestines. Incubation period: two to six weeks is required for completion of the life cycle of the worm.
- Period of communicability: as long as pregnant female worms are discharging eggs onto the skin around the bottom – usually around two weeks.
- Exclusion: none but treatment is recommended.

Treatment

- Effective drug treatments are available from the child's GP or over the counter from a pharmacy. All members of the family will require treatment.
- Good hand hygiene after toilet and before eating will reduce the risk of spread

Do's and Don'ts

- ✓ Do encourage high standards of basic hygiene.
- ✓ Do recommend a consultation with the GP or pharmacist.
- ✓ Do be aware that transmission is uncommon in schools.
- ✗ Don't forget that threadworm infection can lead to lack of sleep, irritability and loss of concentration.

Tuberculosis (TB)

Facts

- TB is an infectious disease caused by inhalation of infected droplets during prolonged close exposure with an infected person (tubercle bacillus being discharged in the sputum).
- TB usually affects the lungs but can affect other parts of the body, such as lymph glands, bones, intestines etc.
- Symptoms occur gradually. These include fever, particularly in the evening, night sweats, dry cough, loss of weight, swelling of glands in the neck and armpit.
- Incubation period: 4 - 12 weeks.
- Period of communicability: the person remains infectious until diagnosed and treated. They would normally be non infectious after two weeks of treatment.
- Exclusion: to be excluded until medically advised to return. Normally for pulmonary TB exclude for at least two weeks from the start of treatment.

Treatment

- This would normally be arranged by a Consultant Paediatrician or Chest Physician who will monitor therapy.
- Drugs for the treatment of TB would be given for about six months. It is important to take all medication as prescribed and complete the course.

Prevention

- BCG vaccination is effective in protecting against tuberculosis. This is given to all children at about 13 years of age and to higher risk infants.
- In the event of a confirmed pulmonary TB case, close household contacts will be screened by the Chest Physician. The CCDC will assess whether more extensive contact tracing is indicated.

Do's and Don'ts

- ✓ Do encourage participation in the BCG immunisation programme.
- ✓ Do contact the CCDC for advice on contact tracing and whether screening is required.

Verrucae and warts

Facts

- Plane warts, which are flat topped, are most common on the face and the back of the hands.
- A verruca is a wart on the foot. Clusters are not uncommon in schools, the infection being spread by children walking in bare feet.
- Warts are caused by a virus and are infectious. They are most likely to be spread in schools by skin to skin contact and by walking barefoot on gym floors and in swimming pools.
- Most warts will eventually disappear without any treatment, as the body builds up immunity to the virus. Because the body develops immunity to the virus it is unusual to develop another wart once the first one has completely gone.
- One-fifth of verrucae disappear within 6 months without treatment and two-thirds of all warts disappear within two years without treatment.
- Incubation period: 1 - 20 months, usually two - three months.
- Period of communicability: uncertain but probably at least as long as visible lesions persist.
- Exclusion: none

Treatment

- As a rule it is better to let them clear up on their own, unless they are very painful, restricting the function of the affected area, or have spread and a number of warts have developed.
- A foam or felt protective pad available from chemists shops will help to relieve discomfort caused by verrucae.
- When treatment is indicated this involves the application of a chemical or electric current or by freezing the wart. They can also be removed surgically.
- Proprietary treatments are available from chemists shops.
- All treatments for warts involve some pain and none of them guarantee a cure. Many resolve spontaneously.

Do's and Don'ts

- ✓ Do allow children with verrucae to take part in barefoot activities if a verruca sock is used correctly or the lesion is covered with a waterproof plaster.

Whooping cough (pertussis)

Facts

- A highly infectious bacterial disease spread by coughing and sneezing and direct contact with nasal discharge.
- Symptoms include running nose followed quickly by a repeated violent cough. The child may become blue while coughing due to lack of oxygen. When the coughing stops the child breathes in quickly producing an audible 'whoop'. Vomiting is common during coughing. The cough gradually becomes less severe, but may last several months. Adolescents may not have a typical cough.
- Since the introduction of whooping cough vaccine the incidence has fallen considerably.
- Complications include pneumonia, convulsions and brain damage.
- Incubation period: 6 - 20 days.
- Period of communicability: from start of runny nose until five days after appropriate antibiotics have started (up to three weeks if antibiotics are not given early).
- Exclusion: until five days after starting antibiotics.

Treatment

- Treatment is usually at home and should include early treatment with appropriate antibiotics. Hospitalisation is common in babies and toddlers.

Do's and Don'ts

- ✓ Do advise parents to see GP.
- ✓ Do allow the child to return to school after exclusion period even if they are still coughing.
- ✓ Do realise they may be tired at school if they are still coughing at night.
- ✓ Do encourage parents to have their children immunised against whooping cough.

Appendix 1

Date

Direct line number 020 8532 6363

Fax number 020 8532 6354

Dear Head Teacher/Nursery Manager

Management of an outbreak of diarrhoea and vomiting in the school/nursery

Following your telephone report today, can we advise that, with the help of the school nurse, you consider implementing the following:-

1. Compile a list of the names of affected children (and staff) with dates of onset, class, main symptoms and duration of illness. For follow up purposes, it would be helpful to have the child's address and/or GP details. Please fax a copy of this to the fax number shown above.
2. Keep affected cases off school until symptoms are better (formed stools). Ask parents to seek the advice of the GP if they are worried.
3. Ask supervisors/teachers to encourage the children to wash their hands after going to the toilet and before mealtimes, preferably using disposable paper towels or hand air dryers.
4. Raise level of environment cleaning, especially in toilet areas. Toilet seats, sinks, floors and door handles need daily cleaning using detergent and water with a suitable disinfectant, such as hypochlorite solution (1000ppm) and disposable cloths.

Letter to parents

A letter offering guidance to parents is enclosed which you may wish to distribute.

It would be appreciated if you could report new cases to us daily so that we can monitor the situation. The above control measures should help to prevent the continuing spread of infection and bring the outbreak to an end.

Yours sincerely

Dr Glynis Double
Consultant in Communicable Disease Control

Appendix 2

Date

Direct line number 020 8532 6363
Fax number 020 8532 6354

Dear Parent

There has been an unexpected increase in children affected by diarrhoea and vomiting. This is usually caused by a virus which can spread by unwashed hands or sometimes by coughs and sneezes.

A child who has symptoms should be off school until they feel better with normal stools. Parents are advised to see the GP if the child is unwell, as treatment may be needed to replace fluids.

To prevent spread of infection, it is recommended that all the family regularly wash their hands, especially after going to the toilet and before handling food, and keep surfaces clean in the kitchen and toilet areas to reduce possible contamination.

If there is an outbreak, a local environmental health officer may visit the home or school and request stool samples from symptomatic children to find the cause

Yours sincerely

Dr G Double
Consultant in Communicable Disease Control

Appendix 3

Date

Direct line number 020 8532 6363

Fax number 020 8532 6354

Dear Head Teacher/Nursery Manager

Management of an outbreak of impetigo in the school/nursery

Following your telephone report today, can we advise that, with the help of the school nurse, you consider implementing the following: -

1. Compile a list of the names of affected children (and staff) with dates of onset, class, main symptoms and duration of illness. For follow up purposes, it would be helpful to have the child's address and/or GP details. Please fax a copy of this to the fax number shown above.
2. Keep affected cases off school until symptoms are better.
3. Ask parents to seek the advice of the GP, who may prescribe antibiotics.
4. Ask supervisors/teachers to encourage the children to wash hands after going to the toilet and before mealtimes, preferably using disposable paper towels or hand air dryers.
5. Raise level of environment cleaning, especially of surfaces to remove dust and contamination. Clean using detergent and water with a suitable disinfectant, such as hypochlorite solution (1000ppm), and disposable cloths.

A letter offering guidance to parents is enclosed which you may wish to distribute.

It would be appreciated if you could report new cases to us daily so that we can monitor the situation. The above control measures should help to prevent the continuing spread of infection and bring the outbreak to an end.

Yours sincerely

Dr G Double
Consultant in Communicable Disease

Appendix 4

Date

Direct line number 020 8532 6363

Fax number 020 8532 6354

Dear Parent

There has been an unexpected increase in children affected by a skin infection called impetigo recently. This infection causes red sores with blisters, pus filled spots or golden scabbed lesions especially around the face, head, legs, arms and hands.

The cause is a skin germ, which is very commonly carried on the surface of most people's skin, and is normally harmless to healthy people. It spreads by hand and body contact and from dirty surfaces.

A child who has symptoms should be kept off school until the skin is better and parents are advised to see the GP who may prescribe antibiotic treatment.

Should your child have any of these symptoms, we would suggest regular handwashing, and more frequent baths or showers. Regular changing of clothes and bedding and thorough cleaning of the home, especially surfaces where dust and dirt can collect, would also help.

Yours sincerely

Dr G Double
Consultant in Communicable Disease

Appendix 5

Date

Direct line number 020 8532 6363

Fax number 020 8532 6354

Strictly private and confidential

Dear Head Teacher/Nursery Manager

Pupil's name:..... **Age:**

Address:.....

For your information, the above pupil who attends your school/nursery has developed symptoms of meningococcal infection and is receiving appropriate treatment in hospital. His/her close household and domestic contacts will be followed up and receive information and protective antibiotic treatment, if appropriate.

The risk to other children in the school/nursery from a single case is minimal and under such circumstances there is no need for treatment of contacts, whether they be pupils or staff and the school/nursery can remain open.

If you receive follow-up enquires from worried parents about the risk of their child acquiring meningococcal infection, you may like to give them a copy of the enclosed letter for parents. Further information and leaflets for parents can be obtained from:

The National Meningitis Trust (Tel: 0845 6000 800)
Meningitis Research Foundation (Tel: 080 8800 3344)

I will be happy to answer any questions you may have.

Yours sincerely

Dr G Double
Consultant in Communicable Disease Control

APPENDIX 6

Date

Direct line number 020 8532 6363

Fax number 020 8532 6354

Dear Parent

For your information one of the pupils attending
Nursery/School has recently developed symptoms of meningococcal illness. This is a rare infection, which is highly unlikely to affect other pupils, and, therefore, no preventive treatment is required.

However, we would recommend that you be alert to the symptoms and signs of meningococcal infection so that you can seek medical help urgently in the unlikely event that this could affect your family in the future. The common possible signs and symptoms of meningococcal infection are:

Meningitis	Septicaemia (blood infection)
<ul style="list-style-type: none">• Fever• Headache• Stiff neck• Rash and flu-like symptoms• Vomiting• Discomfort from bright light• Drowsiness or confusion leading to unconsciousness	<ul style="list-style-type: none">• Rash (does not fade on pressure)• Flu-like symptoms• Drowsiness• Confusion• Unconsciousness

If any member of the family becomes very ill with a suspected meningococcal like illness, they should be taken to the nearest Accident and Emergency Department **without delay**.

An information leaflet and advice about meningitis can be obtained from the following voluntary helplines:

National Meningitis Trust

Tel: 0845 6000 800

Meningitis Research Foundation

Tel: 080 8800 3344

Yours sincerely

Dr G Double

Consultant in Communicable Disease Control

Appendix 7

Date:

Direct line number 020 8532 6363
Fax number 020 8532 6354

Dear Parent

Concern has been expressed by parents about the recurring problem of head lice in school. Head lice are very common in both adults and children throughout the country and it is not possible to completely eliminate this problem. However, awareness of the symptoms and taking sensible precautions can help. Adults may carry headlice without symptoms, whereas children tend to have persistent itching of the hair and scratches on the scalp and around the neck.

The best way to prevent spread is to be alert to symptoms and to act on suspicion as follows:-

- Detect adult lice and eggs (nits) by wet combing hair with a narrow toothed comb. This is best done after shampoo and conditioning which loosens the lice. Most lice and nits can be removed by combing.
- If you detect visible lice in large numbers, or a few repeatedly, then visit the GP for treatment. Treatment may be required for all the members of the household who have evidence of lice and you should all be treated at the same time. It is important to follow treatment instructions carefully or it may not work. Treatment must **not** be repeated on children often as it could be harmful
- After treatment, continue to use wet combing regularly at hair washing to prevent a new infestation developing again. Lice will not survive repeated wet combing.

Advise your children of the following:-

- Avoid head to head contact, as lice mostly spread by close head to head contact. Lice cannot fly or jump and, hence, do not spread easily.
- Avoid sharing brushes and combs, which should be cleaned at every hair wash.
- There is no need to stop your children playing with friends who have had a problem. Head lice can affect anyone and no one person is more likely to be infected than any other.
- Children can continue to attend school whilst wet combing and/or treatment is being carried out.

Appendix 7 (continued)

An information leaflet on prevention of head lice is available at school and the school nurse can arrange to give an educational talk and video to a group of parents. If you are interested contact the school office.

Your co-operation will be appreciated in developing a realistic, home based approach to the prevention of head lice, and your patience is requested in understanding problems faced by some families who may require individual help from the school nurse to tackle this problem.

Yours sincerely

Dr G Double
Communicable Disease Control Consultant