Infectious Diseases
7.1 HOW INFECTIONS SPREAD

Attendance at a child care facility may expose a child to the risk of acquiring infectious diseases for several reasons. Young children readily exchange secretions and frequently are not able to perform adequate hand hygiene or cough etiquette. In addition, children and adults with potentially infectious diseases are not always excluded from child care. Staff members face challenges in terms of enforcing recommended hygiene measures including hand hygiene and in maintaining environmental sanitation in child care settings.

There are three primary modes of transmission for spread of microorganisms in child care settings: contact, droplet, and airborne.

Many common infections encountered in the child care setting are transmitted by direct or indirect contact. Direct contact refers to person-to-person spread of an organism through direct physical contact. Indirect contact refers to spread that occurs by means of contact with a contaminated intermediate object (which could include objects such as shared toys), including hands. Contaminated hands are the most common means of transmission of infections in child care settings.

The majority of common viral respiratory and gastrointestinal tract infections and skin infections among young children, including those due to rhinoviruses, respiratory syncytial virus (RSV), rotavirus, noroviruses, hepatitis A virus, and scabies are transmitted by contact. Bacterial and parasitic intestinal tract infections (such as Shiga toxin-producing E. coli (STEC), Shigella, Clostridium difficile, Giardia, and Cryptosporidium) also are transmitted by contact. Cytomegalovirus (CMV) is transmitted by contact with urine and saliva containing CMV.

Transmission via the droplet route occurs when an infected person coughs, sneezes, or talks, generating large droplets. These droplets are propelled a short distance (generally less than three feet) and are deposited on the eyes, nasal mucosa, or mouth of a susceptible host (person). Infections and organisms transmitted by the droplet route include influenza, mumps, pertussis, RSV, and group A streptococcal (GAS) pharyngitis.

Airborne transmission occurs when small droplet nuclei, dust particles, or skin cells containing microorganisms are transmitted to a susceptible host (person) by air currents. Infections that are transmitted by the airborne route may be spread to others who are quite distant in space from the source infection. Varicella (chicken pox), tuberculosis, and measles are examples of infections transmitted by the airborne route.

Bloodborne transmission of infection through blood or blood containing material in child care is rare, but hepatitis B, C, and D, and HIV are viruses that may be transmitted via bloodborne exposures.


7.2 IMMUNIZATIONS

7.2.0.1 Immunization Documentation
Child care facilities should require that all parents/guardians of children enrolled in child care provide written documentation of receipt of immunizations appropriate for each child’s age. Infants, children, and adolescents should be immunized as specified in the “Recommended Immunization Schedules for Persons Aged 0 Through 18 Years—United States” developed by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAPF). Children whose immunizations are not up-to-date or have not been administered according to the recommended schedule should receive the required immunizations, unless contraindicated or for legal exemptions (1,2).

An updated immunization schedule is published annually in the AAP’s Pediatrics and in the CDC’s MMWR and should be consulted for current information. In addition to print versions of the recommended immunization schedules, the current child, adolescent, and catch-up schedules are posted on the Websites of the CDC at http://www.cdc.gov/vaccines/ and the AAP at http://www.aap.org/immunization/.

RATIONALE
Routine immunizations at the appropriate age are the best means of protecting children against vaccine-preventable diseases. Legal requirements for age-appropriate immunizations of children attending licensed facilities exist in almost all states (see http://www.immunize.org/laws/).
Parents/guardians of children who attend unregulated child care facilities should be encouraged to comply with the most recent “Recommended Immunization Schedules” (2).

Immunization is particularly important for children in child care because preschool-aged children have the highest age-specific incidence or are at high risk of complications from many vaccine-preventable diseases (specifically, measles, pertussis, rubella, influenza, varicella [chickenpox], rotavirus, and diseases due to *Haemophilus influenzae type b* (Hib) and pneumococcus) (3).

**COMMENTS**

Early education and child care settings present unique challenges for infection control due to the highly vulnerable population, close interpersonal contact, shared toys and other objects, and limited ability of young children to understand or practice good respiratory etiquette and hand hygiene. Parents/guardians, early childhood caregivers/teachers, and public health officials should be aware that, even under the best of circumstances, transmission of infectious diseases cannot be completely prevented in early childhood or other settings. No policy can keep everyone who is potentially infectious out of these settings (4).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

1.7.0.1 Pre-Employment and Ongoing Adult Health Appraisals, Including Immunization

9.2.3.5 Documentation of Exemptions and Exclusion of Children Who Lack Immunizations

**References**


7.2.0.2 Unimmunized Children

If immunizations have not been or are not to be administered because of a medical condition (contraindication), a statement from the child’s primary care provider documenting the reason why the child is temporarily or permanently medically exempt from the immunization requirements should be on file. If immunizations are not to be administered because of the parents/guardians’ religious or philosophical beliefs, a legal exemption with notarization, waiver or other state-specific required documentation signed by the parent/guardian should be on file (1,2).

The parent/guardian of a child who has not received the age-appropriate immunizations prior to enrollment and who does not have documented medical, religious, or philosophical exemptions from routine childhood immunizations should provide documentation of a scheduled appointment or arrangement to receive immunizations. This could be a scheduled appointment with the primary care provider or an upcoming immunization clinic sponsored by a local health department or health care organization. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible according to the current “Recommended Immunization Schedules for Persons Aged 0 Through 18 Years—United States” from the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Parents/guardians of children who attend an unlicensed child care facility should be encouraged to comply with the “Recommended Immunization Schedules” (6).

If a vaccine-preventable disease to which children are susceptible occurs in the facility and potentially exposes the unimmunized children who are susceptible to that disease, the health department should be consulted to determine whether these children should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

**RATIONALE**

Routine immunization at the appropriate age is the best means of protecting children against vaccine-preventable diseases. Mandates requiring age-appropriate immunization of children attending licensed facilities exist in all states (1). Exclusion of an unimmunized (susceptible) or underimmunized child from the child care facility in the event of a risk of exposure to an outbreak of a vaccine-preventable disease protects the health of the unimmunized or underimmunized child and minimizes potential for further spread of that disease to other children, staff, family, and community members (2).

**COMMENTS**

A sample statement excluding a child from immunizations is: “This is to inform you that [NAME] should not be immunized with [VACCINE] because of [CONDITION, such as immunosuppression]. I expect this condition to persist for ______. [SIGNED], [PRIMARY CARE PROVIDER] [DATE]”

Vaccine Safety and Parental Choice – Some parents/guardians question the safety of routinely recommended vaccines. Sometimes they choose not to have their children fully vaccinated or to delay particular vaccinations. Unfortunately, this leaves the unimmunized child at risk for serious diseases and puts other children and caregivers/teachers who spend time with the unimmunized child at risk (2). Illness and death from vaccine-preventable
diseases, including whooping cough and measles, have occurred in communities where there are unimmunized children who spread these diseases (3,4).

Vaccines are tested to establish safety and effectiveness before they are licensed by the U.S. Food and Drug Administration (FDA). The ACIP, a non-Federal advisory committee makes evidence-based recommendations to the Centers for Disease Control and Prevention (CDC) following review of all data before a new vaccine is recommended. ACIP is one of many reputable sources of information. The Committee on Infectious Diseases makes evidence-based vaccine recommendations to the board of directors of the AAP. There are biased, inaccurate sources of vaccine information which are not based on evidence and often can confuse parents.

Autism allegedly has been associated with specific vaccines or ingredients in vaccines or combinations of vaccines. There is no evidence-based literature to support this association (5). Hesitant parents/guardians should be referred to reputable sources where evidence-based information is provided to assist them in making informed decisions about the benefits of immunization. Sites where reputable information can be found are shown below.

Since 1999, the mission of the AAP’s Childhood Immunization Support Program (CISP) has been to improve the immunization delivery system for children across the nation by developing an infrastructure within the Academy to support its members and provide education and resources for parents and pediatricians on immunization and immunization-related issues (6).

Three sources of accurate information about immunizations are shown below. Each of the sites provides additional sources of information.

a. http://www2.aap.org/immunization/about/programfacts.html - CISP provides education and resources for parents/guardians and pediatricians on immunizations; CISP Goals are:
   1. Promote quality improvement and best immunization practices in community- and office-based primary care settings and other identified medical homes;
   2. Enable pediatricians and pediatric primary care providers to communicate effectively with parents/guardians;
   3. Promote system-wide improvements in the national immunization delivery system;
   4. Provide accurate and up-to-date resources to parents/guardians that address their most frequent immunization concerns (6).

b. http://www.cdc.gov/vaccines/ - This CDC site provides information for health care professionals and parents/guardians about all aspects of immunization including vaccine recommendations, understanding vaccines and their purpose, vaccine misconceptions, and answers to commonly asked questions about vaccines (7).

c. http://www.immunizationinfo.org - The mission of the National Network for Immunization Information (NNii) is to provide the public, health care professionals, policy makers, and the media with up-to-date, scientifically valid information related to immunization to assist with understanding the issues so that informed decisions can be made (8).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARD**

9.2.3.5 Documentation of Exemptions and Exclusion of Children Who Lack Immunizations

**References**


**7.2.0.3 Immunization of Caregivers/Teachers**

Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) as shown in the “Recommended Adult Immunization Schedule” at http://www.cdc.gov/vaccines/schedules/index.html. This schedule is updated annually at the beginning of the calendar year and can be found in Appendix H.

Caregivers/teachers should have received the recommended vaccines in the following categories: (1,2)

a. Vaccines recommended for all adults who meet the age requirements and who lack evidence of immunity (i.e., lack documentation of vaccination or have no evidence of prior infection):
   1. Tdap/Td;
   2. Varicella-zoster;
   3. MMR (measles, mumps, and rubella);
   4. Seasonal influenza;
   5. Human papillomaviruses (HPV) (eleven through twenty-six years of age);
   6. Others as determined by the ACIP and state and local public health authorities.
b. Recommended if a specific risk factor is present:
   1. Pneumococcal;
   2. Hepatitis A;
   3. Hepatitis B;
   4. Meningococcal;
   5. Others as determined by the ACIP and state and local public health authorities.

c. If a staff member is not appropriately immunized for medical, religious or philosophical reasons, the child care facility should require written documentation of the reason.

d. If a vaccine-preventable disease to which adults are susceptible occurs in the facility and potentially exposes the unimmunized adults who are susceptible to that disease, the health department should be consulted to determine whether these adults should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

RATIONALE
Routine immunization of adults is the best means of preventing vaccine-preventable diseases. Vaccine-preventable diseases of adults represent a continuing cause of morbidity and mortality and a source of transmission of infectious organisms. Vaccines, which are safe and effective in preventing these diseases, need to be used in adults to minimize disease and to eliminate potential sources of transmission (1-3).

COMMENTS
Several of the vaccines recommended routinely for adults will prevent diseases that can be transmitted to children in the child care setting, including pertussis, varicella, measles, mumps, rubella and influenza. One dose of Tdap is a new recommendation for all adults and is especially important for those in close contact with infants. Adults often spread pertussis (whooping cough) to vulnerable infants and young children. Yearly influenza vaccination of adults in contact with children is also an especially important way to protect young infants. Hepatitis A vaccine is not recommended for routine administration to caregivers/teachers; however, hepatitis A vaccine can be administered to any person seeking protection from hepatitis A virus (HAV). Hepatitis A is an illness that often spreads to caregivers/teachers in early education and child care settings. Caregivers/teachers should be aware of the availability of hepatitis A vaccine. As of the printing of this edition, hepatitis A and B, pneumococcal and meningococcal vaccines are only recommended for adults with high risk conditions or in high risk settings unless requested.

Caregivers/teachers who do not complete the recommended immunization series put themselves, and children for whom they care, at risk. For additional information on adult immunization, visit the CDC Website on immunizations and vaccines at http://www.cdc.gov/vaccines/.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARD
1.7.0.1 Pre-Employment and Ongoing Adult Health Appraisals, Including Immunization

References

7.3 RESPIRATORY TRACT INFECTIONS
7.3.1 GROUP A STREPTOCOCCAL (GAS) INFECTIONS

7.3.1.1 Exclusion for Group A Streptococcal (GAS) Infections
A child with a symptomatic group A streptococcal (GAS) respiratory tract infection should be excluded from child care until 24 hours after antibiotics targeting GAS have been initiated (1) and the child is able to fully participate in activities (2). A child does not need to be sent home early for skin infections because of GAS.

Parents/guardians of children exposed to a child with documented GAS infection should be notified of the exposure and observe their child for signs or symptoms of disease. Since the risk of secondary transmission is so low, chemoprophylaxis for contacts after a GAS infection in child care facilities generally is not recommended (1).

RATIONALE
Streptococcal respiratory tract infections and scarlet fever resulting from GAS have been reported in children in child care, but are not a major occurrence (3). GAS respiratory tract infections may resolve without treatment; however, symptomatic GAS respiratory tract infections can be complicated by pneumonia, arthritis, rheumatic fever, and glomerulonephritis (4). Streptococcal toxic shock syndrome is designated as a notifiable disease at the national level (5). A notifiable disease is any disease that is required by law to be reported to state or local health departments.

Early identification (“strep” throat, fever, headache, rash) and treatment of GAS infection in children and adults are important in reducing the likelihood of complications of the infection and transmission of disease to others. Consultation with the local health department is advised when one case of invasive disease (e.g., toxic shock, necrotizing
fasciitis) or two or more cases of localized streptococcal infection occurs in the same room in a child care facility.

**COMMENTS**

For additional information regarding GAS respiratory tract infection, consult the current edition of the *Red Book* from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

3.6.1.1 Inclusion/Exclusion/Dismissal of Children
3.6.1.2 Staff Exclusion for Illness
3.6.1.3 Thermometers for Taking Human Temperatures
3.6.1.4 Infectious Disease Outbreak Control
3.6.2.1 Exclusion and Alternative Care for Children Who Are Ill

**References**


**NOTES**

Content in the STANDARD was modified on 8/9/2017.

7.3.2.1 **Informing Caregivers/Teachers of Group A Streptococcal (GAS) Infection**

Parents/guardians who become aware that their child is infected with group A streptococci (GAS), has strep throat, or has scarlet fever, should inform caregivers/teachers within twenty-four hours.

When exposure to GAS infection occurs and when appropriate, caregivers/teachers, in cooperation with health department officials, should inform parents/guardians of other children who attend the facility, that their children may have been exposed. GAS is a notifiable disease. A notifiable disease is any disease that is required by law to be reported to state or local health departments.

**RATIONALE**

Periodically, the incidence of rheumatic fever appears to increase. Identification and treatment of streptococcal infections of the respiratory tract are central to preventing rheumatic fever (1). Therefore, awareness of the occurrence of GAS infection in child care is important. Adult child care staff members are not immune to GAS infections and may be carriers of organisms that cause disease in children.

When two or more cases of GAS disease occur, interventions are available to limit transmission of GAS infection. Consultation with health department authorities is advised when outbreaks of GAS infection occur in child care facilities. This information may be useful to the exposed child’s primary care provider if the exposed child develops illness.

**COMMENTS**

Sample letters of notification to parents/guardians that their child may have been exposed to an infectious disease are contained in the publication of the American Academy of Pediatrics (AAP), *Managing Infectious Diseases in Child Care and Schools*, 2nd Ed. For additional information regarding GAS infections, consult the current edition of the *Red Book* from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

3.6.1.1 Inclusion/Exclusion/Dismissal of Children
3.6.4.3 Notification of the Facility About Infectious Disease or Other Problems by Parents/Guardians

**Reference**


---

**7.3.2**

**HAEMOPHILUS INFLUENZAE TYPE B (HIB)**

**7.3.2.1 Immunization for Haemophilus Influenzae Type B (Hib)**

All children in a child care facility should have received age-appropriate immunizations with a *Haemophilus influenzae* type b (Hib) conjugate containing vaccine (1). Staff and children in child care who are not immunized or not age-appropriately immunized (those under the age of 4 years) against invasive Hib disease do not need to be excluded from the child care setting unless there is another reason for exclusion (2). Please reference Standard 3.6.1.1: Inclusion/Exclusion/Dismissal of Children for a comprehensive list of exclusion criteria.

**RATIONALE**

Appropriate immunization of children with a Hib conjugate-containing vaccine prevents the occurrence of disease and decreases the rate of spread of this organism, thereby decreasing the risk of transmission to others (3).

**COMMENTS**

Transmission of Hib may occur among unimmunized young children in group child care, especially children younger than twenty-four months of age. Hib causes pneumonia, meningitis, joint and bone infection, heart infection, and epiglottitis. In an outbreak of invasive Hib
disease in child care, rifampin prophylaxis may be indicated for all non-pregnant contacts, especially when unimmunized or incompletely immunized children attend the child care facility (3).

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARDS**
3.6.1.1 Inclusion/Exclusion/Dismissal of Children
7.2.0.1 Immunization Documentation
7.2.0.2 Unimmunized Children
7.2.0.3 Immunization of Caregivers/Teachers
7.3.2.2 Informing Parents/Guardians of *Haemophilus Influenzae* Type B (Hib) Exposure

**References**

**NOTES**
Content in the STANDARD was modified on 8/9/2017.

### 7.3.2.2 Informing Parents/Guardians of *Haemophilus Influenzae* Type B (Hib) Exposure

When a child with invasive *Haemophilus influenzae* type b (Hib) infection is in care, the facility should inform parents/guardians of other children who are unimmunized or incompletely immunized that they may have been exposed to the Hib bacteria and may have risk of developing serious Hib disease. Consultation with health department authorities or the primary health care provider of the unimmunized or incompletely immunized child is recommended.

Staff and children in child care who are not immunized or not age-appropriately immunized (under the age of four years) against invasive Hib disease do not need to be excluded from the child care setting unless there is another reason for exclusion (1). Staff should get the Hib vaccine if recommended by their primary health care provider. Please reference Standard 3.6.1.1: Inclusion/Exclusion/Dismissal of Children for a comprehensive list of exclusion criteria.

**RATIONALE**
There is a risk of secondary cases of invasive Hib disease occurring among child care contacts of a child with invasive Hib disease. Risk of secondary cases of invasive Hib disease occurring among child care attendees is greatest among, and may be limited to, children younger than four years of age who are not immunized, not age-appropriately immunized, or have certain immune deficiencies (2).

**COMMENTS**
Sample letters of notification to parents/guardians that their child may have been exposed to an infectious disease are contained in the current edition of *Managing Infectious Diseases in Child Care and Schools* (AAP).

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARDS**
3.6.1.1 Inclusion/Exclusion/Dismissal of Children
7.2.0.1 Immunization Documentation
7.2.0.2 Unimmunized Children
7.2.0.3 Immunization of Caregivers/Teachers
7.3.2.1 Immunization for *Haemophilus Influenzae* Type B (Hib)

**References**

**NOTES**
Content in the STANDARD was modified on 8/9/2017.

### 7.3.2.3 Informing Public Health Authorities of Invasive *Haemophilus Influenzae* Type B Cases

Invasive disease due to *Haemophilus influenzae* type b (Hib) is designated as a notifiable disease at the national level and local and/or state public health department authorities should be notified immediately about cases of invasive Hib infections involving children or caregivers/teachers in the child care setting. Facilities should cooperate with health department officials in notifying parents/guardians of children who attend the facility about exposure to children with invasive Hib disease. This may include providing local health department officials with names and telephone numbers of parents/guardians of children in classrooms or facilities involved.

The health department may recommend rifampin, an antimicrobial agent taken to prevent infection, for children and staff members, to prevent secondary spread of invasive Hib disease in the facility (1). Antimicrobial prophylaxis is not recommended for pregnant women because the effect of rifampin on the fetus has not been established.

**RATIONALE**
There is a risk of secondary cases of invasive Hib disease among susceptible child care contacts of children with invasive Hib disease. Rifampin treatment of children exposed to a child with Hib disease can reduce the prevalence of Hib respiratory tract colonization in treated children and reduce the subsequent risk of invasive Hib infection,
3.6.4.3	Center, Large Family Child Care Home


(See Appendix G.)

COMMENTS
For additional information regarding Hib disease, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.6.4.3 Notification of the Facility About Infectious Disease or Other Problems by Parents/Guardians
3.6.4.4 List of Excludable and Reportable Conditions for Parents/Guardians

References

7.3.3 INFLUENZA

7.3.3.1 Influenza Immunizations for Children and Caregivers/Teachers

The parent/guardian of each child six months of age and older should provide written documentation of current annual vaccination against influenza unless there is a medical contraindication or philosophical or religious objection. Children who are too young to receive influenza vaccine before the start of influenza season should be immunized annually beginning when they reach six months of age.

Staff caring for all children should receive annual vaccination against influenza. Ideally people should be vaccinated before the start of the influenza season (as early as August or September) and immunization should continue through March or April.

RATIONALE
The American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP) recommend that influenza vaccination of all children begins at six months of age, and adolescents and adults begin before or during the influenza season. Children who are at high risk of influenza complications and respiratory tract infections such as influenza are scattered in out-of-home child care settings. The risk of complications from influenza is greater among children less than two years of age. Infants less than six months of age represent a particularly vulnerable group because they are too young to receive the vaccine. Therefore, people responsible for caring for these children should be immunized (1,2).

Seasonal influenza vaccine should be offered to all children as soon as the vaccine is available, even as early as August or September; a protective response to immunization remains throughout the influenza season. Immunization efforts should continue throughout the entire influenza season, even after influenza activity has been documented in a community. Each influenza season often extends well into March and beyond, and there may be more than one peak of activity in the same season. Thus, immunization through at least May 1st can still protect recipients during that particular season and also provide ample opportunity to administer a second dose of vaccine to children requiring two doses in that season (1).

Children who are too young to receive the influenza vaccine before the start of influenza season should be immunized when they reach six months of age, if influenza vaccination is still recommended at that time. Child contacts who are vaccine-eligible should be vaccinated.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
7.3.3.2 Influenza Control
7.3.3.3 Influenza Prevention Education

References

7.3.3.2 Influenza Control

When influenza is circulating in the community, facilities should encourage parents/guardians to keep children with symptoms of acute respiratory tract illness with fever at home until their fever has subsided for at least twenty-four hours without use of fever reducing medication.

Caregivers/teachers with symptoms of acute respiratory tract illness with fever also should remain at home until their fever subsides for at least twenty-four hours.

RATIONALE
The Centers for Disease Control and Prevention (CDC) recommends that caregivers/teachers encourage parents/guardians of sick children to keep the children home and
away from their regular child care setting until the children have been without fever for twenty-four hours, to prevent spreading illness to others (1).

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARDS**

| 3.6.1.1 | Inclusion/Exclusion/Dismissal of Children |
| 7.3.3.1 | Influenza Immunizations for Children and Caregivers/Teachers |
| 7.3.3.2 | Influenza Control |

**Reference**

**7.3.3.3**

**Influenza Prevention Education**
The child care facility should provide refresher training for all staff and children to include emphasis on the value of influenza vaccine, respiratory hygiene, cough etiquette, and hand hygiene at the beginning of each influenza season (usually considered to be September or October with a peak in February and March). Staff and children should be encouraged to practice these behaviors. Necessary equipment and supplies (e.g., disposable tissues and hand hygiene materials) should be made available.

**RATIONALE**
Although immunization is the single best way to prevent influenza, appropriate hygiene including respiratory hygiene, cough etiquette, and hand hygiene have been shown to reduce spread of respiratory tract infections. In order to be effective, hygiene-based interventions need to be periodically reinforced. Influenza immunizations are recommended for healthy children and adolescents six months through eighteen years of age, for all adults including household contacts and caregivers/teachers of all children younger than five years and health care professionals (1).

**COMMENTS**
For more information, see the Centers for Disease Control and Prevention (CDC) “Preventing the Spread of Influenza (the Flu) in Child Care Settings: Guidance for Administrators, Care Providers, and Other Staff” at http://www.cdc.gov/flu/professionals/infectioncontrol/childcaresettings.htm.

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARD**

| 7.3.3.2 | Influenza Control |

**Reference**

**7.3.4**

**MUMPS**

**7.3.4.1**

**Mumps**
Mumps is a contagious viral disease characterized by swelling of one or more salivary glands, usually the parotid glands. Any child or caregiver/teacher with suspected mumps should be excluded until the diagnosis of mumps or another infectious disease requiring exclusion is ruled out. Children or caregivers/teachers with proven mumps infection should be excluded for five days following the onset of parotid gland swelling (1).

Due to the risk of transmission and to control outbreaks of mumps, consider excluding children without documentation of vaccination with one or more doses of MMR vaccine or laboratory evidence of immunity including those children who have been exempted from this immunization. Excluded children can be readmitted immediately after immunization. Children who continue to be exempted from mumps immunization because of medical, religious, or other reasons should be excluded until at least twenty-six days after the onset of parotitis in the last person with mumps in the affected child care facility. Adults born during or after 1957 should have received one dose of MMR vaccine unless they have a medical contraindication or can provide laboratory evidence of immunity.

During an outbreak, a second dose of MMR (measles, mumps, and rubella) should be offered to the following groups:

a. Inadequately immunized people for whom two doses are recommended (preschool-aged children, school and college students, health care professionals, international travelers);

b. Adults born during or after 1957 without evidence of immunity who previously have received one dose of mumps vaccine. Adults born before 1957 generally are considered immune to mumps.

Mumps is designated as a notifiable disease at the national level, and local and/or state public health officials should be notified immediately about suspected cases of mumps involving children or caregivers/teachers in the child care setting. Facilities should cooperate with health department officials in notifying parents/guardians of children who attend the facility about exposures to children or staff with mumps.

**RATIONALE**
Mumps is a vaccine-preventable disease which is uncommon in children who receive at least two doses of live-attenuated MMR vaccine. The virus typically causes a systemic infection with swelling of the salivary glands, usually one or more of the parotid glands. In up to one-third of infections, the person is asymptomatic or has only a mild upper respiratory tract illness. Mumps can cause an infection of the central nervous system (e.g., encephalitis, meningitis),
kidneys, and other organs. Involvement of the ovaries (in females) and testes (males) can occur, especially in those beyond puberty.

Mumps is spread typically by respiratory tract droplets or contact with respiratory tract secretions. The incubation period ranges from twelve to twenty-five days after exposure, typically sixteen to eighteen days. Infected people are contagious from one to two days before parotid swelling until five days after parotid swelling.

Mumps is an infectious disease and, therefore, routine exclusion of infected children is warranted. The American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) have revised the period of communicability to five days after the onset of parotid swelling (1).

Several mumps outbreaks have occurred since 2006 (2,3). Experience with outbreak control for other vaccine-preventable diseases indicates that the control strategy stated in the standard is effective.

**COMMENTS**

For more information on mumps, consult the current edition of the *Red Book* from the AAP.

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARD**

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

**References**


---

**7.3.5 NEISSERIA MENINGITIDIS (MENINGOCOCCUS)**

**7.3.5.1 Recommended Control Measures for Invasive Meningococcal Infection in Child Care**

Identification of an individual with invasive meningococcal infection in the child care setting should result in the following:

1. Immediate notification of the local or state health department;
2. Notification of parents/guardians about child care contacts to the person with invasive meningococcal infection;
3. Assistance with provision of antibiotic prophylaxis and vaccine receipt, as advised by the local or state health department, to child care contacts;
4. Frequent updates and communication with parents/guardians, health care professionals, and local health authorities.

**RATIONALE**

Due to the increased transmissibility of meningococcal infections following close personal contact with oral and respiratory tract secretions of a person with infection, institution of antibiotic prophylaxis within twenty-four hours of diagnosis of the index case is advised. Younger age and close contact with an infected person increases the attack rate of meningococcal disease among child care attendees to several hundred fold greater than the general population. As outbreaks may occur in child care settings, chemoprophylaxis with oral rifampin is the prophylaxis of choice for exposed child contacts. In some cases, intramuscular ceftriaxone may be used as an alternative if a contraindication to oral rifampin exists in the contact (1,2).

In contacts over eighteen years of age, oral rifampin, ciprofloxacin, or intramuscular ceftriaxone, are effective (2,3). Rifampin is not recommended for pregnant women. In addition to chemoprophylaxis with an oral antimicrobial agent, immunoprophylaxis with a meningococcal vaccine of age-eligible contacts in an outbreak setting, if the infection is due to a serogroup contained in the vaccine, may be recommended by the local or state health department (1,2).

**COMMENTS**

For facilities that care for older school-age children, meningococcal vaccine is recommended at eleven or twelve years of age with a second dose administered at sixteen years of age.

For additional information regarding meningococcal disease, consult the current edition of the *Red Book* from the American Academy of Pediatrics (AAP).

**RELATED STANDARD**

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

**References**

7.3.5.2 Informing Public Health Authorities of Meningococcal Infections

Meningococcal disease is designated as notifiable at the national level, and local and/or state public health department authorities should be notified immediately about the occurrence of invasive meningococcal disease in a child care facility. Timely reporting results in early recognition of outbreaks and prevention of additional infections. Facilities should cooperate with their local or state health department officials in notifying parents/guardians of children who attend the facility about exposures to children with invasive meningococcal infections. Early intervention minimizes anxiety and concern that may result from identification of an attendee with an invasive meningococcal infection. This may include providing local health officials with the names and telephone numbers of parents/guardians of children in involved classrooms or facilities.

RATIONALE
Neisseria meningitidis is a cause of serious infections, including meningitis, in young children and adolescents. Infection is spread from person to person by direct contact with respiratory tract droplets that contain N. meningitidis organisms (1,2).

COMMENTS
Sample letters of notification to parents/guardians that their child may have been exposed to an infectious disease are contained in the publication of the American Academy of Pediatrics (AAP), Managing Infectious Diseases in Child Care and Schools, 2nd Ed. For additional information regarding meningococcal disease, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.6.4.3 Notification of the Facility About Infectious Disease or Other Problems by Parents/Guardians
3.6.4.4 List of Excludable and Reportable Conditions for Parents/Guardians

References

7.3.6 PARVOVIRUS B19

7.3.6.1 Attendance of Children with Erythema Infectiosum (EI) (Parvovirus B19)

Children who develop Erythema Infectiosum (EI), also known as fifth disease, following infection with parvovirus B19, should be allowed to attend child care because they are no longer contagious when signs and symptoms appear.

RATIONALE
EI is caused by parvovirus B19. EI begins with fever, headache, and muscle aches, followed by an intensely red rash on the cheeks with a “slapped cheek” appearance. A lace-like rash appears on the rest of the body. Isolation or exclusion of an immunocompetent person with parvovirus B19 infection in the child care setting is not necessary because little to no virus is present in respiratory tract secretions at the time of occurrence of the rash (1,2).

COMMENTS
Parvovirus B19 infections may be more serious in people with certain immune deficiencies and in people with hemolytic anemia such as sickle cell anemia. Parvovirus B19 infection in pregnancy may cause fetal loss or intrauterine growth retardation. For additional information regarding parvovirus B19, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARD
3.6.1.1 Inclusion/Exclusion/Dismissal of Children

References

7.3.7 PERTUSSIS

7.3.7.1 Informing Public Health Authorities of Pertussis Cases

Local and/or state public health authorities should be notified immediately about suspected or confirmed cases of pertussis (whooping cough) involving children or caregivers/teachers in the child care setting. Facilities should cooperate with their local or state health department officials in notifying parents/guardians of children who attend the facility about exposures to children or adults with pertussis. This may include providing health department officials with the names and telephone
numbers of parents/guardians of children in the classrooms or facilities involved.

Guidelines for use of antibiotics and immunization for prevention of pertussis in people who have been in contact with children or adults who have pertussis should be implemented in cooperation with public health department officials. Children and staff who have been exposed to pertussis, especially those who are incompletely immunized, should be observed for respiratory tract symptoms for twenty-one days after the last contact with the infected person.

RATIONALE

Notification of health department officials when suspected or confirmed pertussis occurs in a child or staff member in a child care center will help ensure the following (1-3):

- All children have received age-appropriate immunization;
- Appropriate antibiotic prophylaxis is provided to children and adults exposed to the child first infected with pertussis;
- Children and adults are observed for respiratory tract symptoms.

COMMENTS

Sample letters of notification to parents/guardians that their child may have been exposed to an infectious disease are contained in the current publication of the American Academy of Pediatrics (AAP), Managing Infectious Diseases in Child Care and Schools (1). For additional information regarding pertussis, consult the current edition of the Red Book (2), also from the AAP.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

3.6.4.3 Notification of the Facility About Infectious Disease or Other Problems by Parents/Guardians

3.6.4.4 List of Excludable and Reportable Conditions for Parents/Guardians

REFERENCES


7.3.7.2 Prophylactic Treatment for Pertussis

When there is a known or suspected occurrence of pertussis (whooping cough) in a child care facility, all exposed staff members and children in care regardless of prior immunization status should begin chemoprophylaxis (usually administration of azithromycin, erythromycin, or clarithromycin) and any additional treatment deemed medically necessary by a health care professional before they are allowed to return to the facility (1).

Adults and children who have been in contact with a person infected with pertussis should be monitored closely for respiratory tract symptoms for twenty-one days after the last contact with the infected person.

All adults who will be around children in out-of-home care, should have Tdap as their next tetanus booster. However, if the adults will be working with infants less than twelve months they should have the Tdap regardless of when they received their last tetanus booster (2).

RATIONALE

Even if outbreaks of pertussis in child care facilities have not been reported, children and staff who attend out-of-home child care occasionally contract pertussis. The spread of infection to contacts who are incompletely immunized can be reduced by treating the primary case and susceptible contacts with prophylactic antibiotics, usually azithromycin, erythromycin, or clarithromycin (1-4). Erythromycin is not recommended in children less than one month of age due to increased risk for hypertrophic pyloric stenosis (1-3)

COMMENTS

For additional information regarding pertussis, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

7.3.7.3 Exclusion for Pertussis

Children and staff members with characteristic symptoms of pertussis (whooping cough) should be excluded from child care pending evaluation by a primary care provider. A symptomatic child or staff member with pertussis or suspected pertussis may not return to the facility until:

- Five days after initiation of a course of any of the following antibiotics: azithromycin (full course of treatment is five days), erythromycin (full course of treatment is fourteen days), or clarithromycin (full course of treatment is seven days) antimicrobial therapy;
- The medical condition allows;
- The child’s need for care does not compromise the caregiver’s/teacher’s ability to provide for the health and safety of the other children in the group.
Untreated adults should be excluded until twenty-one days after onset of cough.

RATIONALE
Even if outbreaks of pertussis in child care facilities have not been reported, children and staff who attend out-of-home child care occasionally contract pertussis. The spread of infection to contacts who are incompletely immunized can be reduced by treating the primary case and susceptible contacts with prophylactic antibiotics (1-4).

COMMENTS
For additional information regarding pertussis, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.6.1.1 Inclusion/Exclusion/Dismissal of Children
3.6.1.2 Staff Exclusion for Illness
3.6.1.3 Thermometers for Taking Human Temperatures
3.6.1.4 Infectious Disease Outbreak Control
3.6.2.1 Exclusion and Alternative Care for Children Who Are Ill

References

7.3.8 RESPIRATORY SYNCYTIAL VIRUS (RSV)

7.3.8.1 Attendance of Children with Respiratory Syncytial Virus (RSV) Respiratory Tract Infection
Respiratory syncytial virus (RSV) is a common cause of respiratory tract infection in infants and young children, although infection in all ages may occur. Children with known RSV infection may return to child care once symptoms have resolved, temperature has returned to normal, the child can participate in child care activities and the child’s care does not result in more care than the staff can provide without compromising the health and safety of other children.

Parents/guardians and staff need to be aware that the period of RSV shedding is usually three to eight days but shedding may last longer, especially in young infants from whom virus can be shed in nasal secretions and saliva for three to four weeks following infection.

RATIONALE
RSV is a well-known cause of respiratory tract illness in children. Almost all children are infected at least once with RSV by two years of age and reinfection is common. In contrast to older children and adults who develop upper respiratory tract infections, RSV is one of the most frequent causes of lower respiratory tract infections including bronchiolitis (fever, cough, wheezing, and increased respiratory rate) or pneumonia in infants and young children less than two years of age. RSV is responsible for greater than one hundred twenty-five thousand hospitalizations, mostly in infants and young children each year. Some 1% to 2% of previously healthy infants require hospitalization for bronchiolitis and up to 5% of these infants may require mechanical ventilation. Infants and children with weakened immune systems, specific types of heart problems, and those born prematurely have even greater difficulty with this infection (1,2).

Because RSV circulation is most common in the U.S. during a defined time period (generally November to March), and increased levels of RSV-specific antibody have been shown to decrease disease severity and/or prevent lower respiratory tract involvement, some infants and young children who meet specific criteria as outlined by the American Academy of Pediatrics (AAP) may benefit from receiving monthly injections (prophylaxis to prevent disease) of a monoclonal antibody (palivizumab) (2). Palivizumab does not treat someone already infected with RSV. For most patients infected with RSV, the disease is self-limited; no anti-viral therapy is available.

During an outbreak of RSV in a child care setting, most children and staff will be exposed before the occurrence of specific symptoms. Most viral respiratory tract illnesses, including RSV infections, are self-limited and go undiagnosed.

Transmission of virus occurs through close contact with respiratory tract secretions (2). Infants with chronic heart and lung problems and immunocompromised children may be at high risk for complications. Parents/guardians of such children should be alerted that a child with RSV has been diagnosed in their group.

Limiting the spread of RSV by using good hand hygiene practices, prohibiting sharing of food; bottles; toothbrushes; or toys, and disinfecting surfaces will be important to reducing the risk of RSV transmission in such situations.

COMMENTS
RSV is a major viral illness in children, especially children two years of age and younger. A critical aspect of RSV prevention among high risk infants is education of parents/guardians and other care providers about the importance of
Streptococcus Pneumoniae

7.3.9

Immunization with Streptococcus Pneumoniae Conjugate Vaccine (PCV13)

Pneumococcal conjugate (PCV13) vaccine is recommended for all children from two through fifty-nine months of age, including children in child care facilities. The vaccine is recommended to be administered at two, four, six, and twelve through fifteen months of age (1-3,5). Healthy children between twenty-four and fifty-nine months of age who are not immunized completely for their age should be administered one dose of PCV13 (3,5).

Children two years of age or older at high risk of invasive disease caused by Streptococcus pneumoniae (including sickle cell disease, asplenia, HIV, chronic illness, cochlear implant or immunocompromised) who have received their recommended doses of PCV should receive S. pneumoniae polysaccharide vaccine two or more months after receipt of the last dose of PCV (1-3,5).

RATIONALE

Appropriate immunization of children with S. pneumoniae conjugate vaccine prevents the occurrence of invasive disease and decreases transmission to others.

Pneumococcal disease among children including children in out-of-home child care due to strains in the PCV7 vaccine has decreased since introduction of PCV7 vaccine that was used until the licensure of PCV13 by the U.S. Food and Drug Administration (FDA) and recommended for use by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP) (3-5). PCV13 provides protection from invasive disease from six additional pneumococcal serotypes. The risk of contacting invasive pneumococcal disease is highest in children less than sixty months of age. The risk for invasive disease is greatest in infants, young children, elderly people and children of some American Indian populations (2,3).

COMMENTS

The pneumococcal conjugate vaccine containing thirteen pneumococcal serotypes (PCV13) will expand coverage against six additional serotypes of S. pneumoniae not contained in PCV7 (5).

For additional information regarding S. pneumoniae disease, consult the current edition of the Red Book from the AAP.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARD

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

References


Chapter 7: Infectious Diseases
Secondary spread of *S. pneumoniae* in child care has been reported, but the degree of risk of secondary spread in child care facilities is unknown (1). Prophylaxis of contacts after the occurrence of a single case of invasive *S. pneumoniae* disease is not recommended.

Infants and young children who are not immunized or who are not age-appropriately immunized should receive a dose of PCV13 and should be scheduled for completion of the “Recommended Childhood Immunization Schedules” from the American Academy of Pediatrics (AAP), Centers for Disease Control and Prevention (CDC), and American Academy of Family Physicians (AAFP) to provide protection from invasive pneumococcal disease (2-6). (See Appendix G.)

For additional information regarding *S. pneumoniae* disease, consult the current edition of the *Red Book* from the AAP.

### RELATED STANDARDS

#### 3.6.4.3 Notification of the Facility About Infectious Disease or Other Problems by Parents/Guardians

#### 3.6.4.4 List of Excludable and Reportable Conditions for Parents/Guardians

### References

organisms are spread by inhalation of a small particle aerosol produced by coughing or sneezing by an adult or adolescent with contagious (active) pulmonary tuberculosis. Transmission usually occurs in an indoor environment. Tuberculosis is not spread via contact with objects such as clothes, dishes, floors, and furniture.

**COMMENTS**

The two stages of tuberculosis are:

- **a.** Latent tuberculosis infection (LTBI), reflected by a reactive TST or IGRA and the absence of symptoms;
- **b.** Active tuberculosis (tuberculosis disease), reflected by a reactive TST or IGRA and the presence of symptoms, including but not limited to cough, fever, and weight loss.

Virtually all tuberculosis is transmitted from adults and adolescents with tuberculosis disease. Infants and young children with active tuberculosis are not likely to transmit the infection to other children or adults because they generally are unable to forcefully cough out organisms into the air.

A TST should be placed and interpreted by an experienced health care professional. IGRA is only recommended for immunocompetent children four years of age and older, adolescents, and adults.

For additional information regarding tuberculosis, consult the current edition of the *Red Book* from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

- **3.6.1.1** Inclusion/Exclusion/Dismissal of Children
- **7.3.10.2** Attendance of Children with Latent Tuberculosis Infection or Active Tuberculosis Disease

**References**


**7.3.10.2 Attendance of Children with Latent Tuberculosis Infection or Active Tuberculosis Disease**

Children with active tuberculosis disease may attend group child care once effective therapy has been instituted, adherence to therapy has been documented, and clinical symptoms are absent. Local health officials or a primary care provider may recommend return to out-of-home child care once a child is considered non-infectious to others.

Children, adolescents, and adults with latent tuberculosis infection (LTBI) (reactive tuberculin skin test [TST] or a positive interferon-gamma release assay [IGRA] without evidence of active tuberculosis disease) may attend group child care. Appropriate therapy in consultation with a primary care provider is recommended to prevent progression to active tuberculosis disease (1).

**RATIONALE**

Efforts to prevent transmission of tuberculosis in child care should focus on permitting children with active tuberculosis disease to attend group child care only after the child is considered non-infectious to others. Children with latent tuberculosis are not infectious to others and may attend group child care but should receive appropriate therapy.

**COMMENTS**

For additional information regarding tuberculosis, consult the current edition of the *Red Book* from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

- **3.6.1.1** Inclusion/Exclusion/Dismissal of Children
- **7.3.10.1** Measures for Detection, Control, and Reporting of Tuberculosis

**Reference**


**7.3.11 UNSPECIFIED RESPIRATORY TRACT INFECTION**

**7.3.11.1 Attendance of Children with Unspecified Respiratory Tract Infection**

Children without fever who have mild symptoms associated with the common cold, sore throat, croup, bronchitis, rhinitis, runny nose (rhinorrhea), or ear infection (otitis media) should not be denied admission to child care, sent home from child care, or separated from other children in the facility unless their illness is characterized by one or more of the following conditions:

1. The illness has a specified cause that requires exclusion, as determined by other specific performance standards in Child and Staff Inclusion/Exclusion/Dismissal, Standards 3.6.1.1 through 3.6.1.4;
2. The illness limits the child’s comfortable participation in child care activities;
3. The illness results in a need for more care than the staff can provide without compromising the health and safety of other children (1).

Treatment with antibiotics should not be required or otherwise encouraged as a condition for attendance of children with mild respiratory tract infections unless directed by the primary health care provider and/or local health officials.
Rationale
The incidence of acute diseases of the respiratory tract, including the common cold, croup, bronchitis, pneumonia, and ear infections (otitis media), is common in infants and young children, whether they are cared for at home or attend out-of-home facilities. However, children in child care experience more frequent respiratory tract infections when compared to children cared for at home (2). Infants and young children may have more upper respiratory infections when they first enter out-of-home group child care (1,2).

Routine hand hygiene and cough etiquette may reduce the incidence of most acute upper respiratory tract infections among children in child care. Frequently, infected children shed viruses before they are symptomatic, and some infected children never become overly ill. Therefore, exclusion criteria based on symptoms will not reduce transmission of upper respiratory tract infections among child care attendees.

Parents/guardians may pressure their primary care provider to prescribe antibiotics because they believe that antibiotics will shorten the duration of exclusion from child care. Primary health care providers and caregivers/teachers should reinforce an understanding of the ineffectiveness of antibiotics on duration of viral upper respiratory tract infection and should attempt to ensure children remain in child care unless they meet exclusion criteria. Please refer to Standard 3.6.1.1: Inclusion/Exclusion/Dismissal of Children for a comprehensive list of exclusion criteria.

Comments
Uncontrolled coughing, difficult or rapid breathing, and wheezing (if associated with difficult breathing) may represent severe illness requiring medical evaluation before readmission to the facility.

For additional information regarding unspecified respiratory tract infections, consult a child care health consultant, primary health care provider, and/or the local health department. For additional information, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP) and Managing Infectious Diseases in Child Care and Schools (AAP).

Type of Facility
Center, Large Family Child Care Home

Related Standards
3.6.1.1 Inclusion/Exclusion/Dismissal of Children
3.6.1.2 Staff Exclusion for Illness
3.6.1.3 Thermometers for Taking Human Temperatures
3.6.1.4 Infectious Disease Outbreak Control

References

Notes
Content in the STANDARD was modified on 8/9/2017.

7.4 Enteric (Diarrheal) Infections and Hepatitis A Virus (HAV)

7.4.0.1 Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections
Facilities should employ the following procedures, in addition to those stated in Child and Staff Inclusion/Exclusion/Dismissal, Standards 3.6.1.1-3.6.1.4, to prevent and control infections of the gastrointestinal tract (including diarrhea) or hepatitis A (1,2):

Exclusion:

a. Toilet trained children who develop diarrhea should be removed from the facility by their parent/guardian. Diarrhea is defined as stools that are more frequent or less formed than usual for that child and not associated with changes in diet.

b. Diapered children should be excluded if stool is not contained in the diaper, stool frequency exceeds two or more stools above normal for that child during the program day, blood or mucus in the stool, abnormal color of stool, no urine output in eight hours, jaundice (when skin and white parts of the eye are yellow, a symptom of hepatitis A), fever with behavior change, or looks or acts ill.

c. Decisions about caring for the child while awaiting parent/guardian pick-up should be made on a case-by-case basis providing care that is comfortable for the child considering factors such as the child’s age, the surroundings, potential risk to others and the type and severity of symptoms the child is exhibiting. The child should be supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. If symptoms allow the child to remain in their usual care setting while awaiting pick-up, the child should be separated from other children by at least 3 feet until the child leaves to help minimize exposure of staff and children not previously in close contact with the child. All who have been in contact with the ill child must wash their hands. Toys, equipment, and surfaces used by the ill child should be cleaned and disinfected after the child leaves.

d. Caregivers/teachers with diarrhea as defined in Standard 3.6.1.2 should be excluded. Separation and exclusion of children or caregivers/teachers should not be deferred pending health assessment or laboratory testing to identify an enteric pathogen.
E. Exclusion for diarrhea should continue until diastered children have their stool contained by the diaper (even if the stools remain loose), when toilet-trained children are not having “accidents”, and when stool frequency is no more than 2 stools above normal for that child during the time in the program day.

F. Exclusion for hepatitis A virus (HAV) should continue for one week after onset of illness and after all contacts have received vaccine or immune globulin as recommended.

G. Alternate care for children with diarrhea or hepatitis A should be provided in facilities for children who are ill that can provide separate care for children with infections of the gastrointestinal tract (including diarrhea) or hepatitis A.

Informing parents/guardians and public health:

A. The local health department should be informed immediately of the occurrence of HAV infection or an increased frequency of diarrheal illness in children or staff in a child care facility.

B. If there has been an exposure to a person with hepatitis A or diarrhea in the child care facility, caregivers/teachers should inform parents/guardians, in cooperation with the health department, that their children may have been exposed to children with HAV infection or to another person with a diarrheal illness.

C. If a child or staff member is confirmed to have hepatitis A disease (HAV), all other children and staff in the group should be checked to be sure everyone who was exposed has received the hepatitis A vaccine or immune globulin within 2 weeks of exposure.

Return to Care:

A. Children can be readmitted when they are able to fully participate in program activities without the caregivers/teachers having to compromise their ability to care for the health and safety of other children in the group.

B. Children and caregivers/teachers who excrete intestinal pathogens but no longer have diarrhea generally may be allowed to return to child care once the diarrhea resolves, except for the case of infections with Shigella, Shiga toxin-producing Escherichia coli (STEC), or Salmonella enterica serotype Typhi. For Shigella and STEC, resolution of symptoms and two negative stool cultures are required for readmission, unless state requirements differ. For Salmonella serotype Typhi, resolution of symptoms and three negative stool cultures are required for return to child care. For Salmonella species other than serotype Typhi, documentation of negative stool cultures are not required from asymptomatic people for readmission to child care.

Rationale

Intestinal organisms, including HAV, cause disease in children, caregivers/teachers, and close family members (1,2). Disease has occurred in outbreaks within centers and as sporadic episodes. Although many intestinal agents can cause diarrhea in children in child care, rotavirus, other enteric viruses, Giardia intestinalis, Shigella, and Cryptosporidium have been the main organisms implicated in outbreaks.

Caregivers/teachers should always observe children for signs of disease to permit early detection and implementation of control measures. Facilities should consult the local health department to determine whether the increased frequency of diarrheal illness requires public health intervention.

The most important characteristic of child care facilities associated with increased frequencies of diarrhea or hepatitis A is the presence of young children who are not toilet trained. Contamination of hands, communal toys, and other classroom objects is common and plays a role in transmission of enteric pathogens in child care facilities.

Studies frequently find that fecal contamination of the environment is common in centers and is highest in infant and toddler areas, where diarrhea or hepatitis A are known to occur most often. Studies indicate that the risk of diarrhea is significantly higher for children in centers than for age-matched children cared for at home or in small family child care homes. The spread of infection from children who are not toilet trained to other children in child care facilities, or to their household contacts is common, particularly when Shigella, rotavirus, Giardia intestinalis, Cryptosporidium, or HAV are the causal agents (1,2).

With recommendations for administration of rotavirus vaccine between two and six months of age and 2 doses of hepatitis A vaccine given at least 6 months apart between 12 and 23 months, rates of disease due to rotavirus and hepatitis A have decreased. To decrease diarrheal disease in child care due to all pathogens, staff and parents/guardians must be educated about modes of transmission as well as practical methods of prevention and control. Staff training in hand hygiene, combined with close monitoring of compliance, is associated with a significant decrease in infant and toddler diarrhea (1,2). Staff training on a single occasion, without close monitoring, does not result in a decrease in diarrhea rates; this finding emphasizes the importance of monitoring as well as education. Therefore, appropriate hygienic practices, hygiene monitoring, and education are important in limiting diarrheal infections and hepatitis. Asymptomatic children can still easily transmit infection to susceptible adults who often develop signs and symptoms of disease and may become seriously ill.

Comments

Sample letters of notification to parents/guardians that their child may have been exposed to an infectious disease are contained in the current publication of the American Academy of Pediatrics (AAP), Managing Infectious Diseases in Child Care and Schools. For additional information regarding enteric (diarrheal) and HAV infections, consult the current edition of the Red Book, also from the AAP.

Type of Facility

Center, Large Family Child Care Home
Caring for Our Children: National Health and Safety Performance Standards

**RELATED STANDARDS**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.2.5</td>
<td>Toilet Learning/Training</td>
</tr>
<tr>
<td>3.2.1.1</td>
<td>Type of Diapers Worn</td>
</tr>
<tr>
<td>3.2.1.2</td>
<td>Handling Cloth Diapers</td>
</tr>
<tr>
<td>3.2.1.3</td>
<td>Checking for the Need to Change Diapers</td>
</tr>
<tr>
<td>3.2.1.4</td>
<td>Diaper Changing Procedure</td>
</tr>
<tr>
<td>3.2.1.5</td>
<td>Procedure for Changing Children's Soiled Underwear/Pull-Ups and Clothing</td>
</tr>
<tr>
<td>3.2.2.1</td>
<td>Situations that Require Hand Hygiene</td>
</tr>
<tr>
<td>3.2.2.2</td>
<td>Handwashing Procedure</td>
</tr>
<tr>
<td>3.2.2.3</td>
<td>Assisting Children with Hand Hygiene</td>
</tr>
<tr>
<td>3.2.2.4</td>
<td>Training and Monitoring for Hand Hygiene</td>
</tr>
<tr>
<td>3.2.2.5</td>
<td>Hand Sanitizers</td>
</tr>
<tr>
<td>3.3.0.1</td>
<td>Routine Cleaning, Sanitizing, and Disinfecting</td>
</tr>
<tr>
<td>3.3.0.2</td>
<td>Cleaning and Sanitizing Toys</td>
</tr>
<tr>
<td>3.3.0.3</td>
<td>Cleaning and Sanitizing Objects Intended for the Mouth</td>
</tr>
<tr>
<td>3.3.0.4</td>
<td>Cleaning Individual Bedding</td>
</tr>
<tr>
<td>3.3.0.5</td>
<td>Cleaning Crib Surfaces</td>
</tr>
<tr>
<td>3.4.2.1</td>
<td>Animals that Might Have Contact with Children and Adults</td>
</tr>
<tr>
<td>3.4.2.2</td>
<td>Prohibited Animals</td>
</tr>
<tr>
<td>3.4.2.3</td>
<td>Care for Animals</td>
</tr>
<tr>
<td>3.6.1.1</td>
<td>Inclusion/Exclusion/Dismissal of Children</td>
</tr>
<tr>
<td>3.6.1.2</td>
<td>Staff Exclusion for Illness</td>
</tr>
<tr>
<td>3.6.1.3</td>
<td>Thermometers for Taking Human Temperatures</td>
</tr>
<tr>
<td>3.6.1.4</td>
<td>Infectious Disease Outbreak Control</td>
</tr>
<tr>
<td>3.6.2.2</td>
<td>Space Requirements for Care of Children Who Are Ill</td>
</tr>
<tr>
<td>3.6.2.3</td>
<td>Qualifications of Directors of Facilities That Care for Children Who Are Ill</td>
</tr>
<tr>
<td>3.6.2.4</td>
<td>Program Requirements for Facilities That Care for Children Who Are Ill</td>
</tr>
<tr>
<td>3.6.2.5</td>
<td>Caregiver/Teacher Qualifications for Facilities That Care for Children Who Are Ill</td>
</tr>
<tr>
<td>3.6.2.6</td>
<td>Child-Staff Ratios for Facilities That Care for Children Who Are Ill</td>
</tr>
<tr>
<td>3.6.2.7</td>
<td>Child Care Health Consultants for Facilities That Care for Children Who Are Ill</td>
</tr>
<tr>
<td>3.6.2.8</td>
<td>Licensing of Facilities That Care for Children Who Are Ill</td>
</tr>
<tr>
<td>3.6.2.9</td>
<td>Information Required for Children Who Are Ill</td>
</tr>
<tr>
<td>3.6.2.10</td>
<td>Inclusion and Exclusion of Children from Facilities That Serve Children Who Are Ill</td>
</tr>
<tr>
<td>4.9.0.1</td>
<td>Compliance with U.S. Food and Drug Administration Food Sanitation Standards, State and Local Rules</td>
</tr>
<tr>
<td>4.9.0.2</td>
<td>Staff Restricted from Food Preparation and Handling</td>
</tr>
<tr>
<td>4.9.0.3</td>
<td>Precautions for a Safe Food Supply</td>
</tr>
<tr>
<td>4.9.0.4</td>
<td>Leftovers</td>
</tr>
<tr>
<td>4.9.0.5</td>
<td>Preparation for and Storage of Food in the Refrigerator</td>
</tr>
<tr>
<td>4.9.0.6</td>
<td>Storage of Foods Not Requiring Refrigeration</td>
</tr>
<tr>
<td>4.9.0.7</td>
<td>Storage of Dry Bulk Foods</td>
</tr>
<tr>
<td>4.9.0.8</td>
<td>Supply of Food and Water for Disasters</td>
</tr>
<tr>
<td>4.9.0.9</td>
<td>Cleaning Food Areas and Equipment</td>
</tr>
<tr>
<td>9.2.3.1</td>
<td>Food and Nutrition Service Policies and Plans</td>
</tr>
<tr>
<td>9.2.3.11</td>
<td>Infant Feeding Policy</td>
</tr>
<tr>
<td>9.4.2.1</td>
<td>Contents of Child's Records</td>
</tr>
<tr>
<td>9.4.2.2</td>
<td>Pre-Admission Enrollment Information for Each Child</td>
</tr>
<tr>
<td>9.4.2.3</td>
<td>Contents of Admission Agreement Between Child Care Program and Parent/Guardian</td>
</tr>
<tr>
<td>9.4.2.4</td>
<td>Contents of Child's Primary Care Provider's Assessment</td>
</tr>
<tr>
<td>9.4.2.5</td>
<td>Health History</td>
</tr>
<tr>
<td>9.4.2.6</td>
<td>Contents of Medication Record</td>
</tr>
<tr>
<td>9.4.2.7</td>
<td>Contents of Facility Health Log for Each Child</td>
</tr>
<tr>
<td>9.4.2.8</td>
<td>Release of Child's Records</td>
</tr>
</tbody>
</table>

**Appendix A:** Signs and Symptoms Chart

**Appendix G:** Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger

**References**


**NOTES**

Content in the STANDARD was modified on 4/5/2017.

### 7.4.0.2 Staff Education and Policies on Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections

To prevent and control infections of the gastrointestinal tract (mainly diarrhea) and hepatitis A, facilities should follow these guidelines, conduct staff education, and follow policies:

a. The facility should conduct continuing education for staff members to address:
   1. Methods of germ transmission that cause diarrhea and hepatitis A; Symptoms of diarrhea and disease associated with hepatitis A virus (HAV) infection; and
   2. Prevention of diarrhea and disease associated with hepatitis A virus (HAV) infection.

b. All caregivers/teachers, food handlers, and maintenance staff should receive continuing education and monitoring concerning hand hygiene and cleaning of environmental surfaces as specified in the facility’s plan.
c. At least annually, the director should review all procedures related to preventing diarrhea and HAV infections. Each caregiver/teacher, food handler, and maintenance person should review a written copy of these procedures or view a video, which should include age-specific criteria for inclusion and exclusion of children who have a diarrheal illness or HAV infection and infection control procedures.

d. Guidelines for administration of immunization against HAV should be enforced to prevent infection in contacts of children and adults with hepatitis A disease (1,2).

RATIONALE
Routine immunization of infants with rotavirus vaccine (3) and of toddlers and older children with hepatitis A vaccine has decreased rates of these diseases in child care centers (4,5). In addition, staff training in hygiene and monitoring of staff compliance reduces the spread of diarrhea (1).

Caregivers/teachers should observe children for signs of disease to identify early detection and implementation of control measures. Facilities should consult the local health department to determine whether the increased frequency of diarrheal illness requires public health intervention.

COMMENTS
Hepatitis A vaccine is not recommended for routine administration to caregivers/teachers but it can be administered to any person seeking protection from HAV (2). Caregivers/teachers should be informed of the availability of hepatitis A vaccine.

Hepatitis A vaccine is recommended for all children beginning at twelve months of age (6). Unimmunized infants and toddlers can develop HAV. They are usually asymptomatic or mildly ill and can easily transmit infection to susceptible adults who often develop signs and symptoms of disease including jaundice and who may become seriously ill.

For additional information regarding enteric (diarrheal) and HAV infections, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS

3.6.1.2 Staff Exclusion for Illness
3.6.1.3 Thermometers for Taking Human Temperatures
3.6.1.4 Infectious Disease Outbreak Control
7.4.0.1 Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections

Appendix G: Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger
Appendix H: Recommended Immunization Schedule for Adults Aged 19 Years or Older

References

Additional Reference

NOTES
Content in the STANDARD was modified on 4/5/2017.

7.4.0.3 Disease Surveillance of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections

The child care facility should cooperate with local health authorities in notifying all staff and parents/guardians of other children who attend the facility of possible exposure to hepatitis A, and diarrheal agents including Shiga toxin-producing E. coli (STEC), Shigella, Salmonella, Campylobacter, Giardia intestinalis, and Cryptosporidium.

RATIONALE
Intestinal organisms, including hepatitis A virus (HAV), cause disease in children, caregivers/teachers, and others in the household including close family members (1-7). Disease has occurred in outbreaks within centers and as sporadic episodes. Although many intestinal agents can cause diarrhea in children in child care, rotavirus, other enteric viruses, Giardia intestinalis, Shigella, and Cryptosporidium have been the main organisms implicated in outbreaks.

Caregivers/teachers should observe children for signs of disease to permit early detection and implementation of
control measures. Facilities should consult the local health department to determine whether the increased frequency of diarrheal illness requires public health intervention.

**COMMENTS**

Children who have completed the immunization series for rotavirus and HAV are likely to be protected against infections with these pathogens (1,2).

Sample letters of notification to parents/guardians that their child may have been exposed to an infectious disease can be found in the current publication of the American Academy of Pediatrics’ (AAP’s) Managing Infectious Diseases in Child Care and Schools. For additional information, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARD**

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

**REFERENCES**


**7.4.0.4 Maintenance of Records on Incidents of Diarrhea**

The facility should maintain a record of children and caregivers/teachers who have diarrhea while at home or at the facility. This record should include:

- The child or caregiver’s/teacher’s name;
- Dates the child or caregiver/teacher is ill;
- Reason for diarrhea, if known;
- Whether the child or caregiver/teacher was in attendance at the child care facility during the diarrhea episode;
- Any leakage of feces from the diaper while the child was in attendance at the child care facility.

Infection with certain enteric diseases or pathogens (cryptosporidiosis, giardiasis, hepatitis A virus [HAV], salmonellosis, Shiga toxin-producing E. coli [STEC], shigellosis) is designated as notifiable at the national level. The facility should notify the local health department authorities whenever there have been two or more children with diarrhea in a given classroom or three or more unrelated children (not siblings) with diarrhea within the facility within a two-week period or occurrence of an enteric agent which is notifiable at the national level.

**RATIONALE**

Disease surveillance and reporting to the local health department authorities are critical in preventing and controlling diseases in the child care setting. A major purpose of surveillance is to allow early detection of disease and prompt implementation of control measures. Ascertaining whether a child who attends a facility is ill is important when evaluating childhood illnesses; ascertaining whether an adult who works in a facility or is a parent/guardian of a child attending a facility is ill is important when considering a diagnosis of hepatitis A and other diseases transmitted by the fecal-oral route. Cases of these infections in household contacts may require questioning about illness in the child attending child care, testing the child for infection, and possible use of hepatitis A vaccine or immune globulin in contacts. Information concerning infectious disease in a child care attendee, staff member, or household contact should be communicated to public health authorities, to the child care director, to all staff, and to all parents/guardians with children in the facility.

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARDS**

3.6.4.3 Notification of the Facility About Infectious Disease or Other Problems by Parents/Guardians

3.6.4.4 List of Excludable and Reportable Conditions for Parents/Guardians

**7.5 CONJUNCTIVITIS**

**7.5.1 Conjunctivitis (Pinkeye)**

Conjunctivitis (pinkeye), defined as redness and swelling of the covering of the white part of the eye (1), may result from a number of causes. Bacteria, viruses, allergies, chemical reactions, and immunological conditions may manifest as redness and discharge from one or both eyes. Management of pinkeye should involve frequent hand hygiene to prevent the spread (1). Children and staff with conjunctivitis (pinkeye) should not be excluded from child care unless:

- They are unable to participate in activities;
- Care for other children would be compromised because of the care required by the child with conjunctivitis;
- The person with conjunctivitis meets any of the following exclusion criteria outlined in Standard 3.6.1.1; or
Chapter 7: Infectious Diseases

d. A health care professional or health department recommends exclusion of the person with conjunctivitis.

Children and staff in close contact with a person with conjunctivitis should be observed for symptoms and referred for evaluation, if necessary. If two or more children in a group care setting develop conjunctivitis in the same period, seek advice from the program’s child care health consultant or public health authority about how to prevent further spread (1). Children who have severe prolonged symptoms should be evaluated by their primary care provider (1).

RATIONALE

Hand contact with eye, nose, and oral secretions is the most common way that organisms causing conjunctivitis are spread from person to person. Careful hand hygiene and sanitizing of surfaces and objects exposed to infectious secretions are the best ways to prevent spread.

 Conjunctivitis may be caused by both infectious and non-infectious conditions. The length of time that a person is considered contagious due to a bacterial or viral conjunctivitis depends on the organism. Antibiotic eye drops and oral medications may decrease the time that a person is considered to be contagious from a bacterial conjunctivitis. For viral conjunctivitis, the contagious period continues while the signs and symptoms are present (1).

COMMENTS

Occasionally, conjunctivitis might occur in several children at the same time or within a few days of each other. Some children with conjunctivitis may have other symptoms including fever, nasal congestion, respiratory, and gastrointestinal tract symptoms.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARD

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

Reference


NOTES

Content in the STANDARD was modified on 3/31/17.

7.5.2 ENTEROVIRUSES

7.5.2.1 Enterovirus Infections

Enterovirus is a form of severe respiratory illness (1). Enteroviruses may cause one or more symptoms including cough, strep throat (pharyngitis), mouth sores or ulcers, chest pain, rashes, headaches, diarrhea, muscle aches, and pink eye (conjunctivitis). These symptoms usually are accompanied by fever. A common enterovirus infection in young children is “hand-foot-and-mouth disease” in which fever and blister-like eruptions in the mouth and/or a rash (usually on the palms and soles) may occur. Children and staff with enterovirus infections should not be excluded from child care unless:

a. They are unable to participate in activities;

b. Care for others would be compromised because of the care that the child with enterovirus requires;

c. The person infected with enterovirus has fever or a change in behavior;

d. A health care professional or health department recommends exclusion of the individual(s) with enterovirus infections.

Children and staff in close contact with an infected person should be observed for symptoms of enterovirus infections and referred for evaluation, if indicated.

Supportive care, proper cough and sneeze etiquette, frequent hand hygiene, disposal of facial tissues that contain nasal secretions after each use, and sanitizing surfaces and objects potentially exposed to infectious secretions, are recommended methods for preventing further spread of the infection (2,3). For people with severe or prolonged symptoms, an evaluation by a primary health care provider may be necessary.

RATIONALE

Enterovirus infections are common in children and may be spread by fecal-oral contact and contact with body fluids and secretions (1-3). Enteroviruses may survive for prolonged periods on environmental surfaces. There is no specific treatment for enterovirus infections (4). Shedding of enteroviruses in respiratory and gastrointestinal tract secretions may occur after symptoms have resolved. Shedding from the gastrointestinal tract of previously infected individuals may be prolonged. Therefore, meticulous hand hygiene following toilet use and diaper changing activities should be practiced (4).

COMMENTS

Occasionally, enterovirus infections might occur in several children at the same time or within a few days of each other. Consultation with a child care health consultant and the local health department may be sought when several children have signs and symptoms of an enterovirus infection.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

3.2.3.2 Cough and Sneeze Etiquette

3.3.0.1 Routine Cleaning, Sanitizing, and Disinfecting

3.3.0.2 Cleaning and Sanitizing Toys

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

Appendix K: Routine Schedule for Cleaning, Sanitizing, and Disinfecting
References

NOTES
Content in the STANDARD was modified on 8/9/2017.

7.5.3
HUMAN PAPILLOMAVIRUSES (warts)

7.5.3.1
Human Papillomaviruses (HPV) (warts)
Children and staff with warts should not be excluded from child care.

Human papillomaviruses (HPV) cause a number of skin and mucous membrane infections; the most common infection is the skin wart. These dome shaped, sometimes conical lesions generally appear on fingers, hands, feet, and face. HPV that causes these lesions are spread via person to person contact. However they are not very contagious. Warts do not require covering with an occlusive dressing. Hand hygiene should be regularly practiced to reduce opportunities for transmission of HPV (1,2).

RATIONALE
The length of time that an individual with a skin wart is considered contagious varies. However the presence of a wart likely represents an opportunity for transmission. The time from contact to the appearance of a wart may vary from months to years. In addition to hand hygiene after contact with warts, sharing of clothing and towels should be avoided. People with warts should be discouraged from touching and scratching warts.

COMMENTS
The HPV that causes skin warts differs from the HPV that causes genital warts and cervical cancer. Treatments of skin warts including liquid nitrogen and topical antiviral agents may result in earlier clearance of warts; however, warts may reappear, requiring additional treatments. Over time, most warts disappear without treatment. The appearance of skin warts is a common occurrence; immunocompromised people may have more lesions that may be present for an extended duration. The HPV vaccine does not prevent or treat skin warts.

For more information, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

TYPE OF FACILITY
Center, Large Family Child Care Home

References

7.5.4
IMPETIGO

7.5.4.1
Impetigo
The following should be instituted when children or staff with lesions suspicious for impetigo are identified:

a. Lesions should be covered with a dressing;

b. The individual should be excluded from child care at the end of the day until the child is treated. The child does not need to be sent home prior to the end of the day if the lesions can be covered and kept dry;

c. Consultation from a primary care provider should be sought to initiate antibiotic treatment;

d. An individual may return to child care following receipt of antibiotic treatment for twenty-four hours if the sores can be covered and kept dry (1); and

e. Hand hygiene should be emphasized after contact with lesions, administration of topical medication, or changing of dressings (2).

f. Exclusion should continue if:

g. Care for others would be compromised because of the care required by the child with impetigo;

h. The child with impetigo has fever or a change in behavior;

i. The sores cannot be kept covered and dry;

j. A health care professional or health department official recommends exclusion of the individual with impetigo.

Children and staff in close contact with an affected person should be observed for symptoms of impetigo and referred for evaluation, if indicated. The local health department should be notified if several children develop impetigo.

RATIONALE
Impetigo is a common skin infection, usually caused by either of two different types of bacteria – streptococci and staphylococci. Fluid filled blisters with “honey-colored” scabs often form. Some skin lesions also may appear as red-colored pimples. The lesions may be found on the face, extremities, or other areas of the body. The bacteria may be acquired from contact with another person with impetigo lesions, from sores on one’s own skin at another location, or from contact with surfaces containing bacteria. The bacteria generally enter the skin at an opening or abrasion. Treatment of impetigo may consist of a topical, an oral, or an intravenous medication. Lesions are considered to be
Children and staff in close contact with an affected child should be observed for symptoms of infection and referred for evaluation, if indicated. The local health department should be notified if a caregiver/teacher has a concern that several children have symptoms of lymphadenitis.

Lymphadenitis, an inflammation and generally an enlargement of one or more lymph nodes (glands), may result from both non-infectious and infectious causes. Lymphadenopathy is an enlargement of a lymph node without inflammation. The most common infectious sources of lymphadenitis are bacteria and viruses, with fungi and para sites accounting for fewer infections. Lymphadenitis in children usually is acute, with rapid onset and symptoms involving the lymph nodes of the head and neck. Lymph nodes in other sites, including the groin and on one or both sides of the body may be affected. The affected lymph node(s) may be swollen with areas of redness overlying the swelling and may be painful to touch. In some cases a “chain” of lymph nodes may be palpated. The inflammation of one or more lymph nodes may represent an infectious etiology. Evaluation by a primary care provider may be indicated to define the underlying etiology and to assess potential for transmission and need for treatment.

**Rationale**

Lymphadenitis is a common presentation of a number of infectious and non-infectious etiologies. Most types of infectious lymphadenitis may be described as acute and bilateral, acute and unilateral, and subacute or chronic (1). It is helpful to categorize lymphadenitis because certain infectious organisms are more likely to be associated with one of the three categories. It also is important to identify the infectious organism responsible for the lymphadenitis because this information has implications for management and treatment, including child care inclusion and exclusion policies. Careful hand hygiene and disinfection of surfaces and objects potentially exposed to infectious material are the best ways to prevent spread. The presence of children with lymphadenitis should be noted by caregivers/teachers, and parents/guardians of children should be notified to seek care, if indicated.

**Comments**

Occasionally, lymphadenitis might occur in several children or staff members at the same time or within a few days of each other. For more information, consult the current edition of the *Red Book* from the American Academy of Pediatrics (AAP).

**Type of Facility**

Center, Large Family Child Care Home

**References**

7.5.6 MEASLES

7.5.6.1 Immunization for Measles

All children in a child care facility should have received age-appropriate immunizations with measles, mumps, and rubella (MMR) vaccine or with measles, mumps, rubella, and varicella (MMRV) vaccine (1). If a case of measles occurs in a child care setting, interrupting subsequent spread depends on prompt immunization of people at risk of exposure or people already exposed who cannot provide documentation of measles immunity, including date of immunization. Children and adults in child care who are not immunized or not age-appropriately immunized against measles should be excluded from care immediately if the child care facility has been notified of a documented case of measles occurring in a child or adult in the center. These children should not be allowed to return to the facility until at least two weeks after the onset of rash in the last case of measles, as determined by health department officials.

Adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive one or more doses of MMR vaccine unless they have a medical contraindication, documentation of one or more dose of vaccine, history of measles based on primary care provider diagnosis, or laboratory evidence of immunity.

RATIONALE

Measles is one of the most highly infectious of all infections transmitted by direct contact with infectious droplets or by airborne spread (2). Outbreaks of measles have been reported in unimmunized populations. Transmission to unimmunized people in the U.S. from importation of measles by international travelers occurs on a regular basis (2). Appropriate immunization of children and adults with MMR vaccine prevents the occurrence of measles disease (2). Any case of measles identified in a child or adult in a child care setting should be reported to local or state health department officials immediately (2).

TYPE OF FACILITY

Center, Large Family Child Care Home

REFERENCES


7.5.7 MOLLUSCUM CONTAGIOSUM

7.5.7.1 Molluscum Contagiosum

Molluscum contagiosum is a skin disease, similar to warts, that causes one or more flesh-colored, translucent lesions with small indentations. Some lesions also have an eczema-like appearance to their outer edge. The virus that causes molluscum contagiosum is spread by person-to-person contact. It also may be transmitted by sharing towels and clothing containing residual virus acquired by contact with the lesions of an infected person. The virus may be spread to other sites by scratching and manipulating lesions. Clusters of molluscum-associated lesions commonly occur on the trunk, extremities, and face. People with eczema or who are immunocompromised may have more extensive lesions that are present for prolonged periods of time (1).

The virus causing these lesions is spread via person-to-person or person-to-object to person; however, it is not very contagious. Despite its name, it is more likely that a person will spread the virus to a site on his or her body than to another individual. Lesions do not require covering with a dressing. Hand hygiene should be regularly practiced to reduce opportunities for transmission of the virus causing molluscum contagiosum.

Children and staff with molluscum contagiosum should not be excluded from child care (2).

RATIONALE

The length of time that a person with a molluscum contagiosum lesion is considered contagious varies; however, the presence of a lesion likely represents an opportunity for transmission. The time from contact to the appearance of a lesion or lesions may vary from weeks to months. In addition to hand hygiene after contact with lesions, sharing of clothing and towels should be avoided. People with molluscum contagiosum should be discouraged from touching and scratching their lesions (2).

COMMENTS

Molluscum contagiosum lesions may be pruritic (itchy), resulting in release of virus from and introduction of bacteria into the area. The application of a bag filled with ice may reduce the urge to scratch. Treatment of lesions is a cosmetic issue and does not usually affect resolution. Over time, lesions disappear without treatment.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

3.6.1.1 Inclusion/Exclusion/Dismissal of Children
7.5.3.1 Human Papillomaviruses (HPV) (Warts)


**References**


**PEDICULOSIS CAPITIS (HEAD LICE)**

**7.5.8.1 Attendance of Children with Head Lice**

Children should not be excluded immediately or sent home early from early care and education due to the presence of head lice (1). If head lice are present, children should avoid any head-to-head contact with other children and should avoid the sharing of any headgear while finishing out the day (2).

Parents/guardians of affected children should be notified and informed that their child must be treated before returning to the child care facility. Parents/guardians should be encouraged to follow Integrated Pest Management (IPM) best practices, which entails using the least hazardous means to control pests, including head lice. Pesticides (such as pediculicide, an agent used to destroy lice) are applied according to the manufacturer’s instructions and in a manner that minimizes skin contact, and inhalation (3). In addition to treating the affected child with a pediculicide, machine wash and dry clothing, bed linens and other items that the infested child wore or used during the two days before the treatment with the pediculocide. Use the hot water (130 degrees F) laundry cycle and the high heat drying cycle. Clothing and items that are not washable can be dry cleaned or seal these items in a plastic bag for two weeks. Soak combs and brushes in hot water (at least 130 degrees F) for 5-10 minutes. Vacuum the floor and furniture, particularly where the infested child sat or lay, recognizing that the risk of getting infested by a louse that fell onto a rug, carpet or furniture is very low (3).

Children and staff who have been in close contact with an affected child should be examined and treated if infested, defined as the presence of adult lice or nits (eggs) on a hair shaft within three to four millimeters from the scalp. Do not use fumigant sprays; they can be toxic if inhaled or absorbed through the skin (3).

**RATIONALE**

Head lice infestation in children attending child care is common and is NOT a sign of poor hygiene. Transmission occurs by direct contact with hair of infested people and less commonly by direct contact with personal items of infested people. Head lice survive less than one to two days if they fall off a person and cannot feed; nits cannot hatch and usually die within a week if they are not kept at the same temperature as that found close to the human scalp.

Head lice are not responsible for the spread of any disease, only the discomfort of infestations. The institution of “no-nit” policies before permitting return of an infested child to child care or school are not effective in controlling transmission (1,3).

Child care programs should not institute a “no-nit” policy.

**COMMENTS**

Treatments for head lice generally are safe and effective when used as directed. Some treatments may cause an itching or a burning sensation of the scalp. Most products used to treat head lice are pesticides that can be absorbed through the skin. Therefore, all medicines used for treatment of louse should be used with care and only as directed. Although not medically necessary, removal of nits that are attached within one centimeter of the base of the hair shaft may be manually performed (1). Removing the nits may help in situations where outbreaks are occurring in the group to determine whether a child who has been treated became reinfested after treatment or merely has residual non-viable nits. Utilize your child care health consultant to help with this issue. In addition, the following resources may be useful to help with education and information about treatment from the CDC, AAP and the California Child Care Program: http://www.cdc.gov/parasites/lice/head/treatment.html, http://www.healthycalifornia.org/English/health-issues/conditions/from-insects-animals/Pages/Signs-of-Lice.aspx, and http://cchp.ucsf.edu/sites/cchp.ucsf.edu/files/HeadLice.FCCH.IPM.pdf.

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

5.2.8.1 Integrated Pest Management

5.4.5.1 Sleeping Equipment and Supplies

6.4.2.2 Helmets

**References**


**NOTES**

Content in the STANDARD was modified on 8/25/2016.
7.5.9
TINEA CAPITIS AND TINEA CRURIS (RINGWORM)

7.5.9.1 Attendance of Children with Ringworm

Children with ringworm of the scalp (tinea capitis) or body (tinea corporis) should receive appropriate treatment. Children receiving treatment should not be excluded from child care.

Children and staff in close contact with an affected child should receive periodic inspections for early lesions and should receive therapy, if lesions are noted. Contact with lesions should be avoided. Dry coverings over treated lesions should be encouraged.

Rationale

Ringworm infections result from a fungus that is transmitted by contact with an infected person (scalp and body) and by contact with infected animals (body). Treatment of ringworm of the scalp requires oral medicine for four to six weeks (1). Treatment of ringworm of the body requires topical medicine for a minimum of four weeks (2). Oral therapy is available if lesions are extensive or unresponsive to topical therapy. Direct contact with sources of ringworm should be avoided to prevent transmission (1,2).

Comments

Personal items should not be shared. The lesion resulting from the fungal infection is usually circular (hence the term “ringworm”) but other non-fungal and non-infectious rashes may have a similar appearance. People receiving oral treatment for ringworm of the scalp may attend child care or school. Haircuts, shaving of the scalp, and wearing of head coverings are not indicated for treatment of tinea capitis. Using long sleeves or long pants to cover extremity lesions is sufficient to reduce the shedding of spores and transfer of topical medications from the sores to surfaces in the child care facility.

For additional information regarding ringworm, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

Type of Facility

Center, Large Family Child Care Home

Related Standard

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

References


7.5.10
STAPHYLOCOCCUS AUREUS
SKIN INFECTIONS INCLUDING MRSA

7.5.10.1 Staphylococcus Aureus Skin Infections Including MRSA

The following should be implemented when children or staff with lesions suspicious for Staphylococcus aureus infections are identified:

a. Lesions should be covered with a dressing;
b. Report the lesions to the parent/guardian with a recommendation for evaluation by a primary care provider; and
c. Exclusion is not warranted unless the individual meets any of the following criteria:
   1. Care for other children would be compromised by care required for the person with the S. aureus infection;
   2. The individual with the S. aureus infection has fever or a change in behavior;
   3. The lesion(s) cannot be adequately covered by a bandage or the bandage needs frequent changing; and
   4. A health care professional or health department official recommends exclusion of the person with S. aureus infection (1).

Meticulous hand hygiene following contact with lesions should be practiced (1). Careful hand hygiene and sanitization of surfaces and objects potentially exposed to infectious material are the best ways to prevent spread. Children and staff in close contact with an infected person should be observed for symptoms of S. aureus infection and referred for evaluation, if indicated.

A child may return to group child care when staff members are able to care for the child without compromising their ability to care for others, the child is able to participate in activities, appropriate therapy is being given, and the lesions can be covered (1).

S. aureus skin infections initially may appear as red raised areas that may become pus-filled abscesses or “boils,” surrounded by areas of redness and tenderness. Fever and other symptoms including decreased activity, bone and joint pain, and difficulty breathing may occur when the infection occurs in other body systems. If any of these signs or symptoms occur, the child should be evaluated by his/her primary care provider.

Rationale

S. aureus (also known as “Staph”) is a bacterium that commonly causes superficial skin infections (cellulitis and abscesses). It also may cause muscle, bone, lung, and blood (invasive) infections. One type of S. aureus, called methicillin-resistant S. aureus or “MRSA,” is resistant to one or more classes of antibiotics. S. aureus and MRSA have been the source of attention due to increasing rates of
infections from these bacteria associated with health care associated (HCA) infections and in healthy children and adults in the community. Transmissibility and infectivity is comparable to infections with *S. aureus* without methicillin resistance. Therefore, signs and symptoms, incubation and contagion periods, control of spread, and exclusion guidelines are identical for all *S. aureus* infections, including infections with methicillin resistance or MRSA (1,2).

Most people with skin infections due to *S. aureus* do not develop invasive infections; they may experience recurrent skin infections. Infants and children who are diapered and pre-adolescents and adolescents who participate in team sports may have an increased risk for developing *S. aureus* skin infections. This is likely due to frequent breaks of skin and the sharing of towels. The incubation period for *S. aureus* skin infections is unknown. Some people may carry MRSA without having symptoms of active infection. These people are considered to be “colonized” with *S. aureus*; however, they are not considered to be infectious when they do not have active infection.

*S. aureus* skin infections may occur at sites of skin trauma. Pus and other material draining from skin lesions should be considered to be infectious. Treatment of *S. aureus* skin infections may be accomplished with an oral or an intravenous antibiotic or a combination of both. In some cases, incision and drainage of the lesion(s) alone may be required. In other instances, incision and drainage of smaller lesions with the use of a topical antibiotic may result in a cure. Skin lesions are considered to be infectious until they have healed; therefore, they should be kept covered and dry. Frequent hand hygiene to prevent spread of *S. aureus* should be practiced at home and in child care (1). Evaluation by a primary care provider in people with severe or prolonged symptoms may be indicated.

**COMMENTS**

*S. aureus* skin infections are common, especially among infants wearing diapers and adolescent members of sports teams. Infections may be more common among children where other family members have or have had skin lesions and during the warmer months when skin exposure to trauma may be increased. Shedding of bacteria from skin lesions may occur until the lesion has healed. Occasionally *S. aureus* infections may occur in several children at the same time or within a few days of each other. Consultation with a health care professional and the local health department may be sought when several people have these symptoms.

For additional information for parents/guardians and caregivers/teachers, refer to information posted by the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/mrsa/index.html.

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

Appendix A: Signs and Symptoms Chart

---

**References**


---

### 7.5.11 Scabies

#### 7.5.11.1 Attendance of Children with Scabies

A child who is suspected of having scabies should see a health care provider. If scabies is confirmed, the child should begin treatment before returning to the program. A child with a confirmed case of scabies may be excluded until treatment has begun (1).

**RATIONALE**

Scabies is caused by a mite and manifests as an intensely itchy, red rash triggered by the burrowing of female mites into the skin. These burrows appear as gray or white thread-like crooked lines. Transmission usually occurs through prolonged close person-to-person contact (1,2). Epidemics and localized outbreaks may require stringent and consistent measures to treat contacts of the person infected. Individuals who have had prolonged skin-to-skin contact with people infested by scabies may benefit from prophylactic treatment. Bedding used and clothing worn next to the skin for three days prior to treatment should be washed in hot water and dried in a hot dryer cycle. Items that cannot be laundered should be stored in sealed plastic bags for at least 4 days because scabies mites cannot survive away from humans for more than 4 days (1).

**COMMENTS**

Cleaning with potentially toxic agents is unnecessary and is not effective in reducing transmission of scabies mites. Optimal control is achieved by treatment of infested people and their close contacts.

For additional information, see the Centers for Disease Control and Prevention (CDC) Website at http://www.cdc.gov/parasites/scabies/.

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARD**

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

**References**


**NOTES**

Content in the STANDARD was modified on 8/9/2017.
7.5.12 THRUSH

7.5.12.1 Thrush (Candidiasis)

Children with thrush do not need to be excluded from group settings (1). Careful hand hygiene and sanitization of surfaces and objects potentially exposed to oral secretions including pacifiers and toothbrushes is the best way to prevent spread (1). Toothbrushes and pacifiers should be labeled individually so that children do not share toothbrushes or pacifiers, as specified in Standard 3.1.5.2. The presence of children with thrush should be noted by caregivers/teachers, and parents/guardians of the children should be notified to seek care, if indicated.

Treatment of thrush may consist of a topical or an oral medication. Most people are able to control thrush without treatment. Evaluation by a primary care provider of people with severe or prolonged symptoms may be indicated.

RATIONALE

Thrush is a common infection, especially among infants (1). Thrush is caused by yeast, a type of fungus called Candida. This fungus thrives in warm, moist areas (skin, skin under a diaper, and on mucous membranes). Thrush appears as white patches on the mucous membranes, commonly on the inner cheeks, gums, and tongue, and may cause diaper rash. The yeast that causes thrush lives on skin and mucous membranes of healthy people and is present on surfaces throughout the environment. An imbalance in the normal bacteria and fungi on the skin may cause the yeast to begin growing on the mucous membranes, appearing as white plaques that are adherent. Intermittent thrush may be normal in infants and young children. People with exposure to moisture, those receiving antibiotics, or those with an illness may develop thrush (2).

COMMENTS

Occasionally, thrush might occur in several individuals at the same time or within a couple of days of each other. Consultation with a health care professional and the local health department may be sought when several individuals have these symptoms.

TYPE OF FACILITY

Center, Large Family Child Care Home

RELATED STANDARDS

3.1.5.2 Toothbrushes and Toothpaste
3.3.0.2 Cleaning and Sanitizing Toys
3.3.0.3 Cleaning and Sanitizing Objects Intended for the Mouth
3.6.1.1 Inclusion/Exclusion/Dismissal of Children

References

The risk of disease transmission from an HBV-carrier child or staff member with no behavioral risk factors and without generalized dermatitis or bleeding problems is considered rare. This extremely low risk does not justify exclusion of an HBV-carrier child from out-of-home care, nor does it justify the routine screening of children as possible HBV carriers prior to admission to child care.

HBV transmission in a child care setting is most likely to occur through direct exposure via bites or scratches that break the skin and introduce blood or body secretions from the HBV carrier into a susceptible person. Indirect transmission via blood or saliva through environmental contamination may be possible but has not been documented. Saliva contains much less virus (1/1000) than blood; therefore, the potential infection from saliva is much lower than that of blood.

No data are available to indicate the risk of transmission if a susceptible person bites an HBV carrier. When the HBV statuses of both the biting child and the victim are unknown, the risk of HBV transmission would be extremely low because of the expected low incidence of HBV carriage by children of preschool-age and the low efficiency of disease transmission by bite exposure. Because a bite in this situation is extremely unlikely to involve an HBV-carrier child, screening is not warranted, particularly in children who are immunized appropriately against HBV (1), but each situation should be evaluated individually. In the rare circumstance that an unimmunized child bites a known HBV carrier, the hepatitis B vaccine series should be initiated (4).

**COMMENTS**
Parents/guardians are not required to share information about their child’s HBV status, but they should be encouraged to do so. For additional information regarding HBV consult the current edition of the Red Book from the AAP.

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARDS**
3.1.5.2 Toothbrushes and Toothpaste
3.2.3.4 Prevention of Exposure to Blood and Body Fluids
3.3.0.2 Cleaning and Sanitizing Toys
3.3.0.3 Cleaning and Sanitizing Objects Intended for the Mouth
3.6.1.1 Inclusion/Exclusion/Dismissal of Children

**References**

### 7.6.1.2 Observation and Follow-Up of a Child Who is a Hepatitis B Virus (HBV) Carrier

The primary caregiver/teacher should observe a child who is a known hepatitis B virus (HBV) carrier and the other children in the group for development of aggressive behavior (such as biting or frequent scratching) that might facilitate transmission of HBV. If this type of behavior occurs, the child’s primary care provider or the health department should evaluate the need for immediate disease prevention measures with hepatitis B immune globulin and should reevaluate the child’s continuing attendance in the facility.

**RATIONALE**
Regular assessment of behavioral risk factors and medical conditions of enrolled children who are HBV carriers is important. It is helpful if the center director and primary caregivers/teachers are informed that a known HBV-carrier child is in care. However, parents/guardians are not required to share this information. Most children in child care facilities have been immunized against hepatitis B as part of their routine immunization schedule, minimizing the risk of transmission (1).

**COMMENTS**
For additional information regarding HBV infections, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**
Center, Large Family Child Care Home

**RELATED STANDARD**
3.6.1.1 Inclusion/Exclusion/Dismissal of Children

**Reference**

### 7.6.1.3 Staff Education on Prevention of Bloodborne Diseases

All caregivers/teachers should receive training at employment and annually thereafter as required by the Occupational Safety and Health Administration (OSHA) on how to prevent transmission of bloodborne diseases, including hepatitis B virus (HBV), hepatitis C virus (HCV), and HIV (1).

**RATIONALE**
Efforts to reduce risk of transmitting diseases in child care through hygiene and environmental standards in general should focus primarily on blood precautions, limiting saliva contamination (no sharing of utensils, pacifiers, tooth brushes), and ensuring that children are appropriately immunized against HBV. People, including caregivers/teachers, who may be expected to come into contact with blood as a part of their employment, are required to be trained how to protect themselves from
bloodborne diseases by their employers and be offered hepatitis B vaccine at no charge to them, within ten working days of initial assignment (1,2).

**COMMENTS**

If the employee initially declines hepatitis B vaccination but at a later date, while still covered under the acceptable timeline (ten working days), decides to accept the vaccination, the employer should make hepatitis B vaccination available at that time. The employer should ensure that employees who decline to accept the offer of hepatitis B vaccination sign the Occupational Safety and Health Administration’s (OSHA) “Hepatitis B Vaccine Declination” statement (1). The “Hepatitis B Vaccine Declination” statement can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5708a1.htm.

For additional information regarding HBV and HCV infections, consult the associated chapters in the current edition of the Red Book from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARD**

3.2.3.4 Prevention of Exposure to Blood and Body Fluids

**References**


**7.6.1.4 Informing Public Health Authorities of Hepatitis B Virus (HBV) Cases**

Staff members known to have acute or chronic hepatitis B virus (HBV) infection should not be restricted from work but should receive training on how to prevent transmission of bloodborne diseases. HBV infection is designated as a notifiable disease at the national level. Cases of acute HBV in any child or employee of a facility should be reported to the health department for determination of the need for further investigation or preventive measures (1).

**RATIONALE**

The risk of disease transmission from a HBV-carrier child or staff member with normal behavior and without generalized dermatitis or bleeding problems is considered to be rare. This extremely low risk does not justify exclusion of an HBV-carrier staff member from providing child care, nor does it justify the routine screening of staff as possible HBV carriers prior to admission to child care.

**COMMENTS**

For additional information regarding HBV infections, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

**7.6.1.5 Handling Injuries to a Hepatitis B Virus (HBV) Carrier**

Injuries that lead to bleeding by a hepatitis B virus (HBV) carrier child or adult should be handled promptly in the manner recommended for any such injury in any child or adult using Standard Precautions.

**RATIONALE**

Efforts to reduce the risk of transmitting diseases in child care through hygienic and environmental standards in general should focus primarily on blood precautions and ensuring appropriate immunization of children and adults against HBV (1).

**COMMENTS**

For additional information regarding HBV infections, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARD**

3.2.3.4 Prevention of Exposure to Blood and Body Fluids

**Reference**


**7.6.2 HEPATITIS C VIRUS (HCV)**

**7.6.2.1 Infection Control Measures with Hepatitis C Virus (HCV)**

Standard Precautions, as outlined in Standard 3.2.3.4, should be followed to prevent infection with hepatitis C virus (HCV) infection. Children with HCV infection should not be excluded from out-of-home child care. Hepatitis C is designated as a notifiable disease at the national level and local and/or state public health authorities should be notified about cases of hepatitis C infections involving children or adults in the child care setting.
RATIONALE
The seroprevalence (frequency) of HCV infection in young children is less than 1% and most acute infections are asymptomatic. Transmission risks of HCV in a child care setting are unknown. The general risk of HCV infection from exposure to blood-containing body fluids entering through the skin is estimated to be ten times greater than that of HIV but lower than that of hepatitis B virus (HBV) (1). Transmission of HCV via contamination of mucous membranes (eyes, nose, mouth) or broken skin probably has an intermediate risk between that for blood infected with HIV and HBV (2).

COMMENTS
For additional information regarding HCV infections, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARD
3.2.3.4 Prevention of Exposure to Blood and Body Fluids

References

7.6.3
HUMAN IMMUNODEFICIENCY VIRUS (HIV)

7.6.3.1 Attendance of Children with HIV
Children infected with HIV should be admitted to child care as long as their health status allows participation in program activities. Children who enter child care should not be required to be tested for HIV or to disclose their HIV status (1,2). HIV is not spread by the type of contact that regularly occurs in child care (1). Standard Precautions should be adopted for handling all blood and blood-containing body from all children (1,2).

If exposure to a highly contagious disease (such as measles or chicken pox) occurs at the facility, parents/guardians of all children, including children with HIV, should be notified as they can pose a serious health risk to children with compromised immune systems (1).

RATIONALE
Overall, the risk factor for transmission of HIV is low because HIV is not spread by the type of contact that typically occurs in child care. HIV is not spread through non-bloody saliva, tears, stool, or urine (1).

COMMENTS
If the program is aware of a child attending with positive HIV status and there is a strong risk of transmission of blood-borne pathogens occurring, it is recommended the child’s health care provider, parents/guardian, and the program director meet to assess whether the child can participate in group care activities. Examples of high-risk transmissions are: generalized dermatitis, bleeding problems, or biting (1). A public health authority with expertise in HIV prevention/transmission or the child’s health provider should be consulted as specific issues regarding participation arise.

For additional information regarding HIV, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.2.3.4 Prevention of Exposure to Blood and Body Fluids
3.6.1.1 Inclusion/Exclusion/Dismissal of Children

References

NOTES
Content in the STANDARD was modified on 3/31/17.

7.6.3.2 Protecting HIV-Infected Children and Adults in Child Care
Parents/guardians of all children, including children infected with HIV, should be notified immediately if the child has been exposed to chickenpox, tuberculosis, fifth disease (parvovirus B19), diarrheal disease, measles, or other infectious diseases through contact with other children in the facility. In particular, immune-compromised children who are exposed to measles or chickenpox should be referred immediately to their primary care provider to receive the appropriate preventive measure (immune globulin or immunization) following exposure and decision about readmission to the child care facility (1). Information regarding a child whose immune system does not function properly to prevent infection, whatever the cause, should be available to caregivers/teachers who need to know so they can reduce the likelihood of transmission of infection to the child. Accordingly, infections in other children and staff members in the facility should be brought to the prompt attention of the parent/guardian of the child whose immune system does not function properly. The parent/guardian may elect to seek medical advice regarding the child’s continued participation in the facility. Injuries that lead to bleeding by a child with HIV should be handled promptly using Standard Precautions in the manner recommended for any such injury to any child.
The immune system of children and adults who are infected with HIV often does not function properly to prevent infections. Children and adults with immunosuppression for multiple other reasons are at greater risk for severe complications from several infections including chickenpox, cytomegalovirus (CMV), tuberculosis, Cryptosporidium, Salmonella, and measles virus (1,2). Available data indicate that infection with measles is a more serious illness in HIV-infected children than in children who are not HIV-infected. The first deaths from measles in the United States reported to the Centers for Disease Control and Prevention (CDC) after 1985 were in HIV-infected children.

Caregivers/teachers should know about a child’s special health care needs so they can offer protection for that child. Standard Precautions should be adopted in caring for all adults and all children in out-of-home child care when blood or blood-containing body fluids are handled, to minimize the possibility of transmission of any bloodborne disease.

**COMMENTS**

Staff should have training on Standard Precautions for bloodborne pathogens, HIV and other causes of immune deficiency, confidentiality, and implications of suspicions about HIV status. Annual training on use of Standard Precautions and periodic staff monitoring may increase compliance and staff knowledge of this policy.

All caregivers/teachers should be taught the basic principles of individuals’ rights to confidentiality.

For additional information regarding HIV, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARDS**

3.2.3.4 Prevention of Exposure to Blood and Body Fluids

7.6.3.1 Attendance of Children with HIV

9.4.1.3 Written Policy on Confidentiality of Records

9.4.1.4 Access to Facility Records

9.4.1.5 Availability of Records to Licensing Agency

9.4.1.6 Availability of Documents to Parents/Guardians

**References**


**Rationale**

Unwarranted fear about HIV transmission in child care should be dispelled. Studies examining transmission of HIV support the concept that HIV is not a highly infectious agent (1). The major routes of transmission are through sexual contact, through contact with blood or body fluids containing blood, and from mother to child during the birth process. Several studies have shown that HIV-infected people do not spread the HIV virus to other members of their households except through sexual contact.

HIV has been isolated in low volumes in saliva, urine, and human milk. Transmission of HIV through saliva does not occur. Cases suggest that contact with blood from an HIV-infected person is a possible mode of transmission through contact between broken skin and blood or blood-containing fluids. Theoretically, biting is a possible mode of transmission of bloodborne illness, such as HIV infection. However, the risk of such transmission is rare. If a bite results in blood exposure to either person involved, the U.S. Public Health Service recommends post-exposure follow-up, including consideration of post-exposure prophylaxis (2). Due to risks of disease transmission, as a part of Standard Precautions, no food should be given to a child (or adult) that initially was in the mouth (or pre-chewed) by someone else.

**Comments**

For additional information regarding HIV, consult the current edition of the Red Book from the American Academy of Pediatrics (AAP).

**Type of Facility**

Center, Large Family Child Care Home

**Related Standard**

3.2.3.4 Prevention of Exposure to Blood and Body Fluids

**References**


**7.6.3.4 Ability of Caregivers/Teachers with HIV Infection to Care for Children**

HIV-infected adults who do not have open and uncoverable skin lesions, other conditions that would result in contact with their body fluids, or a transmissible infectious disease may care for children in child care programs. However, immunosuppressed adults with HIV infection may be at increased risk of acquiring infectious agents from children.
Cytomegalovirus (CMV) is a viral infection that is common in children. Up to 70% of children ages 1 to 3 years in group care settings excrete the virus (1). Cytomegalovirus (CMV) is the leading cause of congenital infection in the United States and is responsible for a significant number of serious birth defects. CMV is transmitted primarily through the respiratory tract, and infants can be at risk of acquiring the virus from caregivers or other children at a child care facility.

**Staff Education and Policies on Cytomegalovirus (CMV)**

Staff of childbearing age who care for infants and children should be provided the following information:

- **a.** The increased probability of exposure to cytomegalovirus (CMV) in the child care setting;
- **b.** The potential for fetal damage when CMV is acquired during pregnancy;
- **c.** The importance of hand hygiene measures (especially handwashing and avoiding contact with urine, saliva, and nasal secretions) to lower the risk of CMV;
- **d.** The availability of counseling and testing for serum antibody to CMV to determine the caregiver/teacher’s immune status.

Female employees of childbearing age should be referred to their primary health care provider or to the health department authority for counseling about their risk of CMV infection. This counseling may include testing for serum antibodies to CMV to determine the employee’s immunity against CMV infection.

Since saliva can transmit CMV, staff should be advised not to share cups or eating utensils, kiss children on the lips, or allow children to put their fingers or hands in another person’s mouth.

**RATIONALE**

Based on available data, there is no reason to believe that HIV-infected adults will transmit HIV in the course of their normal child care duties. Therefore, HIV-infected adults who do not: a) have open skin sores that cannot be covered, b) other conditions that would allow contact with their body fluids, or c) a transmissible infectious disease, may care for children in facilities.

Immunosuppressed adults with acquired immunodeficiency syndrome (AIDS) may be more likely to acquire infectious agents from children and should consult with their own primary care providers regarding the advisability of their continuing to work in a facility.

**COMMENTS**

For additional information regarding HIV, consult the current edition of the *Red Book* from the American Academy of Pediatrics (AAP).

**TYPE OF FACILITY**

Center, Large Family Child Care Home

**RELATED STANDARD**

3.2.3.4 Prevention of Exposure to Blood and Body Fluids

**Reference**

7.7.2 HERPES SIMPLEX

7.7.2.1 Disease Recognition and Control of Herpes Simplex Virus

Children with herpetic gingivostomatitis, an infection of the mouth caused by the herpes simplex virus, who do not have control of oral secretions, should be excluded from child care. In selected situations, children with mild disease who are in control of their oral secretions may not need to be excluded. The facility’s child care health consultant or health department officials should be consulted.

Caregivers/teachers with herpetic gingivostomatitis, cold sores, or herpes labialis should do the following:

a. Refrain from kissing and nuzzling children;

b. Refrain from sharing food and drinks with children and other caregivers;

c. Avoid touching the lesions;

d. Wash their hands frequently;

e. Cover any skin lesion with a bandage, clothing, or an appropriate dressing if practical.

Caregivers/teachers should be instructed in the importance of and technique for hand hygiene and other measures aimed at limiting transfer of infected material, such as saliva, tissue fluid, or fluid from a skin sore.

Caregivers/teachers who work in a child care program with young infants should avoid caring for infants including neonates when the caregiver has an active “fever blister” on their lips.

RATIONALE

Initial herpes simplex virus disease in children often produces a sudden illness of short duration characterized by fever and sores around and within the mouth. Illness and viral excretion may persist for a week or more. Multiple, painful sores in the mouth and throat may prevent oral intake and necessitate hospitalization for hydration (1). Recurrent oral herpes is manifested as small, fluid-filled blisters on the lips and entails a much shorter period of virus shedding from sores. Adults and children also can shed the virus in oral secretions in the absence of identifiable sores.

Although the risk of transmission of herpes simplex virus in the child care setting has not been documented, spread of infection within families has been reported and is thought to require direct contact with infected secretions (1). Transmission of herpes simplex in child care is uncommon (2). However, neonates are at the highest risk for disseminated disease.

For additional information regarding herpes simplex, consult the herpes simplex chapter in the current edition of the Red Book from the American Academy of Pediatrics (AAP).
7.7.3 HERPES VIRUS 6 AND 7 (ROSEOLA)

7.7.3.1 Roseola
Children with roseola (exanthema subitum) or clinical evidence of infection with human herpes virus 6 or 7 need not be excluded from child care as long as they are able to participate in normal activities comfortably and staff finds they can care for the child without jeopardizing the health or safety of other children.

RATIONALE
Roseola is a viral disease caused by human herpes virus 6 or 7 (HHV6, HHV7) that causes fever for three to seven days and then, as the fever disappears, a red, raised rash appears often on the trunk with spread to the face and extremities. A seizure may occur as a CNS (central nervous system) manifestation in patients with primary infection. Almost all children have been infected with HHV6 by two years of age. The virus is transmitted to children from healthy adults via saliva. The incubation period is reported to be nine to ten days, so a child may expose others at home and in child care before becoming ill. No antiviral therapy is recommended in otherwise healthy children. The virus, like other herpes viruses, can become latent in the body (virus DNA persists in some cells, including salivary glands) (1).

COMMENTS
Once the rash appears, the child is usually feeling better.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARD
3.6.1.1 Inclusion/Exclusion/Dismissal of Children

Reference

7.7.4 VARICELLA-ZOSTER (CHICKENPOX) VIRUS

7.7.4.1 Staff and Parent/Guardian Notification About Varicella-Zoster (Chickenpox) Virus
The child care facility should notify all staff members and parents/guardians when a case of chickenpox occurs, informing them of the greater likelihood of serious infection in susceptible adults, the potential for fetal damage if infection occurs during pregnancy, and the risk of severe varicella in children or adults with impaired immunity for any reason including HIV infection, steroid use, cancer chemotherapy, or organ transplantation (1,2).

RATIONALE
Prior to introduction of varicella vaccine, about 5% to 10% of adults were susceptible to varicella-zoster virus. Within twenty-four hours after exposure is recognized, susceptible child care staff members who are pregnant and are exposed to children with chickenpox should be referred to health care professionals who are knowledgeable in the area of varicella infection during pregnancy. The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend use of varicella vaccine in non-pregnant susceptible people twelve months of age and older within three days but up to five days after exposure to varicella. When indicated, VariZIG, an immune globulin preparation, or intravenous immune globulin (IGIV) also can be administered following exposure (2).

COMMENTS
Outbreaks of varicella in child care have decreased since institution of the two dose varicella recommendations (3). Sample letters of notification to parents/guardians that their child may have been exposed to an infectious disease are contained in the current edition of Managing Infectious Diseases in Child Care and Schools, a publication of the American Academy of Pediatrics (AAP). For additional information regarding varicella, consult the current edition of the Red Book, also from the AAP.

TYPE OF FACILITY
Center, Large Family Child Care Home

References

7.7.4.2 Exclusion of Children with Varicella-Zoster (Chickenpox) Virus
Children who develop chickenpox should be excluded until all sores have dried and crusted (usually six days). The need for excluding an infected person should be decided based on the recommendations of the person’s primary care provider. If a conflict or question about return to the child care facility arises, the facility should consult their child care health consultant or personnel at the health department. Until the conflict is resolved, readmission should be delayed.

Varicella-zoster virus is the cause of shingles as well as of chickenpox. Staff members or children with shingles (herpes zoster) should keep sores covered by clothing or a dressing until sores have crusted. With shingles, the virus is present in small, fluid-filled blisters, and is spread by direct contact. Sores that are covered seem to pose little risk to susceptible persons. Older children and staff members with herpes zoster should be instructed to wash their hands if they touch
potentially infectious lesions. If a child or staff member has zoster lesions which cannot be covered, they should be excluded until the lesions are crusted and the person is able to function normally and return.

RATIONALE
Exclusion of children infected with varicella-zoster virus may not control illness in child care, but exclusion may help control disease caused by this virus in some people (such as adults, children and adults who have a compromised immune system, and newborn infants). Children should receive two doses of a varicella containing vaccine, the first at twelve through fifteen months of age and the second at four through six years of age. The second dose may be given as early as three months after the first. If the second dose is given one month after the first, it should not be repeated.

Person-to-person transmission of this highly contagious virus occurs by direct contact with vesicular fluid from patients with varicella or by airborne spread from respiratory tract secretions. Patients are most contagious from one to two days before to shortly after onset of the rash. Contagiousness persists until crusting of all lesions.

Prior to introduction of varicella vaccine, about 5% to 10% of adults were susceptible to varicella-zoster virus. All adults without evidence of immunity to varicella should receive two doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only one dose, unless they have a medical contraindication. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., health care personnel and family contacts of people with immunocompromising conditions) or 2) are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).

Evidence of immunity to varicella in adults includes any of the following:

a. Documentation of two doses of varicella vaccine at least four weeks apart;
b. U.S.-born before 1980 (although for health care personnel and pregnant women, birth before 1980 should not be considered evidence of immunity);
c. History of varicella based on diagnosis or verification of varicella by a health care professional (for a patient reporting a history of or presenting with an atypical case, a mild case, or both, health care professionals should seek either an epidemiologic link to a typical varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if performed at the time of acute disease);
d. History of herpes zoster based on health care professional diagnosis or verification of herpes zoster by a health care professional;
e. Laboratory evidence of immunity or laboratory confirmation of disease.

Pregnant women not previously immunized for varicella should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health care facility. The second dose should be administered at a minimum of four weeks after the first dose. Susceptible child care staff members who are pregnant and are exposed to children with chickenpox should be referred to their primary care professional or other health care professionals who are knowledgeable in the area of varicella infection during pregnancy within twenty-four hours after the exposure is recognized.

COMMENTS
Initial viral infection with varicella-zoster virus produces an acute fever and the appearance of chickenpox blisters; reactivation of the virus results in shingles (herpes zoster).

Routine use of varicella vaccine as recommended by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) will reduce the likelihood of transmission of wild type strains of varicella virus (1,2). A zoster vaccine is available for people sixty years of age and older (3).

In mild cases with only a few sores and rapid recovery, an otherwise healthy child may be able to return to child care sooner once the lesions are crusted. Children whose immune system does not function properly and children with more severe cases of chickenpox should be excluded from child care until lesions are crusted.

For additional information regarding varicella, consult the current edition of the Red Book from the AAP.

TYPE OF FACILITY
Center, Large Family Child Care Home

RELATED STANDARDS
3.6.1.1 Inclusion/Exclusion/Dismissal of Children
3.6.1.2 Staff Exclusion for Illness
3.6.1.3 Thermometers for Taking Human Temperatures
3.6.1.4 Infectious Disease Outbreak Control
3.6.2.1 Exclusion and Alternative Care for Children Who Are Ill

References
Chapter 7: Infectious Diseases

7.8 INTERACTION WITH STATE OR LOCAL HEALTH DEPARTMENTS

Prompt reporting of infectious diseases is the foundation of public health surveillance and disease control. Diseases that are reportable in the United States at a national level are included weekly in Morbidity and Mortality Weekly Report (http://www.cdc.gov/mmwr/), and are summarized annually by Centers for Disease Control and Prevention (CDC) in the “Summary of Notifiable Diseases in the United States.” Infectious disease reporting is regulated by individual states. Although details may differ from state to state, every state has regulations mandating that specified diseases or conditions be reported to local or state public health agencies. In general, selected infections with high mortality or large public health implications (such as meningococcal infections, measles, or smallpox) must be reported immediately; other infections (such as pertussis, varicella, or invasive group A streptococcal [GAS] infection) may in some cases be reported in a slightly less emergent fashion (e.g., one to two business days). If child care staff have any question regarding a potentially infectious illness among attendees or staff members, they should consult their local or state public health agency immediately for guidance. Child care health consultants are also very helpful. Caregivers/teachers should understand which infections are reported to local boards of health and which are reported directly to the state health department. For details about regulations for individual states, refer to local and state public health agencies.

7.9 NOTE TO READER ON JUDICIOUS USE OF ANTIBIOTICS

The spread of antimicrobial resistance is an issue of concern to patients and parents/guardians as well as to health care professionals. Children treated with antibiotics are at increased risk of becoming carriers of resistant bacteria. If they develop an illness from resistant bacteria, they may be more difficult to treat and may be likely to fail standard antimicrobial therapy (1,2). While antibiotic therapy for a diagnosis of pharyngitis due to group A streptococci is indicated, for some conditions such as otitis media, antibiotic therapy is only occasionally recommended. For other conditions such as the common cold and nonspecific cough illness/bronchitis, antibiotic therapy is not indicated. Principles of judicious use of antimicrobial agents with detailed supporting evidence were published by the American Academy of Pediatrics (AAP), the American Academy of Family Practice (AAFP), and the Centers for Disease Control and Prevention (CDC) to identify areas where antimicrobial therapy might be curtailed without compromising patient care (1).

References