



St Patrick's Primary School

Management of Infectious

Diseases in Schools.

Information For Parents



Guidance on infection control in schools and other childcare settings in Northern Ireland

Prevent the spread of infections by ensuring: routine immunisation, high standards of personal hygiene and practice, particularly handwashing, and maintaining a clean environment. Please contact the Public Health Agency **Health Protection Duty Room on 0300 555 0119** or

visit www.publichealth.hscni.net or www.gov.uk/government/organisations/uk-health-security-agency if you would like any further advice or information, including the latest guidance. Children with rashes should be considered infectious and assessed by their doctor.

Rashes and skin infections	Recommended period to be kept away from school, nursery or childminders	Comments
Athlete's foot	None	Athlete's foot is not a serious condition. Treatment is recommended
Chickenpox*	Until all vesicles have crusted over	See: Vulnerable children and female staff – pregnancy
Cold sores, (Herpes simplex)	None	Avoid kissing and contact with the sores. Cold sores are generally mild and self-limiting
German measles (rubella)*	Four days from onset of rash (as per "Green Book")	Preventable by immunisation (MMR x 2 doses). See: Female staff – pregnancy
Hand, foot and mouth	None	Contact the Duty Room if a large number of children are affected. Exclusion may be considered in some circumstances
Impetigo	Until lesions are crusted and healed, or 48 hours after commencing antibiotic treatment	Antibiotic treatment speeds healing and reduces the infectious period
Measles*	Four days from onset of rash	Preventable by vaccination (MMR x 2). See: Vulnerable children and female staff – pregnancy
Molluscum contagiosum	None	A self-limiting condition
Ringworm	Exclusion not usually required	Treatment is required
Roseola (infantum)	None	None
Scabies	Child can return after first treatment	Household and close contacts require treatment
Scarlet fever*	Child can return 24 hours after commencing appropriate antibiotic treatment	Antibiotic treatment recommended for the affected child. If more than one child has scarlet fever contact PHA Duty Room for further advice
Slapped cheek (fifth disease or parvovirus B19)	None once rash has developed	See: Vulnerable children and female staff – pregnancy
Shingles	Exclude only if rash is weeping and cannot be covered	Can cause chickenpox in those who are not immune i.e. have not had chickenpox. It is spread by very close contact and touch. If further information is required, contact the Duty Room. SEE: Vulnerable Children and Female Staff – Pregnancy
Warts and verrucae	None	Verrucae should be covered in swimming pools, gymnasiums and changing rooms

Diarrhoea and vomiting illness	Recommended period to be kept away from school, nursery or childminders	Comments
Diarrhoea and/or vomiting	48 hours from last episode of diarrhoea or vomiting	
E. coli O157 VTEC*	Should be excluded for 48 hours from the last episode of diarrhoea	Further exclusion is required for young children aged five years and under and those who have difficulty in adhering to hygiene practices
Typhoid* [and paratyphoid] (enteric fever)	Further exclusion may be required for some children until they are no longer excreting	Children in these categories should be excluded until there is evidence of microbiological clearance. This guidance may also apply to some contacts of cases who may require microbiological clearance
Shigella* (dysenteria)		Please consult the Duty Room for further advice
Cryptosporidiosis*	Exclude for 48 hours from the last episode of diarrhoea	Exclusion from swimming is advisable for two weeks after the diarrhoea has settled

Respiratory infections	Recommended period to be kept away from school, nursery or childminders	Comments
Flu (influenza)	Until recovered	See: Vulnerable children
Tuberculosis*	Always consult the Duty Room	Requires prolonged close contact for spread
Whooping cough* (pertussis)	48 hours from commencing antibiotic 48 hours following commencement of recommended antibiotic therapy, or for 14 days from the onset of illness if untreated.	Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks. The Duty Room will organise any contact tracing necessary. Some individuals that work with vulnerable groups (pregnant women, very young unvaccinated babies) should be excluded from work as soon as a diagnosis of pertussis is suspected until 48 hours following commencement of recommended antibiotic therapy, or for 21 days following the onset of cough if untreated. Contact duty room for more advice
COVID-19 (coronavirus)	Stay at home and avoid contact with other people until you no longer have a high temperature (if you had one) or until you feel better. www.nidirect.gov.uk/articles/symptoms-respiratory-infections-including-covid-19	See: Vulnerable children

Other infections	Recommended period to be kept away from school, nursery or childminders	Comments
Conjunctivitis	None	If an outbreak/cluster occurs, consult the Duty Room
Diphtheria *	Exclusion is essential. Always consult with the Duty Room	Family contacts must be excluded until cleared to return by the Duty Room. Preventable by vaccination. The Duty Room will organise any contact tracing necessary.
Glandular fever	None	
Head lice	None	Treatment is recommended only in cases where live lice have been seen
Hepatitis A*	Exclude until seven days after onset of jaundice (or seven days after symptom onset if no jaundice)	The duty room will advise on any vaccination or other control measure that are needed for close contacts of a single case of hepatitis A and for suspected outbreaks.
Hepatitis B*, C, HIV/AIDS	None	Hepatitis B and C and HIV are bloodborne viruses that are not infectious through casual contact. For cleaning of body fluid spills. SEE: Good Hygiene Practice
Meningococcal meningitis*/septicaemia*	Until recovered	Some forms of meningococcal disease are preventable by vaccination (see immunisation schedule). There is no reason to exclude siblings or other close contacts of a case. In case of an outbreak, it may be necessary to provide antibiotics with or without meningococcal vaccination to close contacts. The Duty Room will advise on any action needed.
Meningitis* due to other bacteria	Until recovered	Hib and pneumococcal meningitis are preventable by vaccination. There is no reason to exclude siblings or other close contacts of a case. The Duty Room will give advice on any action needed
Meningitis viral*	None	Milder illness. There is no reason to exclude siblings and other close contacts of a case. Contact tracing is not required
MRSA	None	Good hygiene, in particular handwashing and environmental cleaning, are important to minimise any danger of spread. If further information is required, contact the Duty Room
Mumps*	Exclude child for five days after onset of swelling	Preventable by vaccination (MMR x 2 doses)
Threadworms	None	Treatment is recommended for the child and household contacts
Tonsillitis	None	There are many causes, but most cases are due to viruses and do not need an antibiotic

* denotes a notifiable disease. It is a statutory requirement that doctors report a notifiable disease to the Director of Public Health via the Duty Room.

Outbreaks: if a school, nursery or childminder suspects an outbreak of infectious disease, they should inform the Duty Room.

Good hygiene practice

Handwashing is one of the most important ways of controlling the spread of infections, especially those that cause diarrhoea and vomiting, and respiratory disease. The recommended method is the use of liquid soap, warm water and paper towels. Always wash hands after using the toilet, before eating or handling food, and after handling animals. Cover all cuts and abrasions with waterproof dressings.

Coughing and sneezing easily spread infections. Children and adults should be encouraged to cover their mouth and nose with a tissue. Wash hands after using or disposing of tissues. If tissues are unavailable sneeze or cough into the crook of the elbow and not hands. Spitting should be discouraged.

Personal protective equipment (PPE). Disposable gloves and disposable plastic aprons must be worn where there is a risk of splashing or contamination with blood/body fluids (for example, nappy or pad changing). Goggles should also be available for use if there is a risk of splashing to the face. Correct PPE should be used when handling cleaning chemicals.

Cleaning of the environment, including toys and equipment, should be frequent, thorough and follow national guidance. For example, use colour-coded equipment, follow Control of Substances Hazardous to Health (COSHH) regulations and correct decontamination of cleaning equipment. Monitor cleaning contracts and ensure cleaners are appropriately trained with access to PPE.

Cleaning of blood and body fluid spillages. All spillages of blood, faeces, saliva, vomit, nasal and eye discharges should be cleaned up immediately (always wear PPE). When spillages occur, clean using a product that combines both a detergent and a disinfectant. Use as per manufacturer's instructions and ensure it is effective against bacteria and viruses and suitable for use on the affected surface. Never use mops for cleaning up blood and body fluid spillages – use disposable paper towels and discard clinical waste as described below. A spillage kit should be available for blood spills.

Laundry should be dealt with in a separate dedicated facility. Soiled linen should be washed separately at the hottest wash the fabric will tolerate. Wear PPE when handling soiled linen. Children's soiled clothing should be bagged to go home, never rinsed by hand. See www.ninfectioncontrolmanual.net/sites/default/files/Laundry_Leaflet_04_16.pdf

Clinical waste. Always segregate domestic and clinical waste in accordance with local policy. Used nappies/pads, gloves, aprons and soiled dressings should be stored in correct clinical waste bags in waste-informed bins. All clinical waste must be removed by a registered waste contractor. All clinical waste bags should be less than two-thirds full and stored in a dedicated, secure area while awaiting collection.

Sharps, eg needles, should be discarded straight into a sharps bin conforming to BS 7320 and UN 3291 standards. Sharps bins must be kept off the floor (preferably wall-mounted) and out of reach of children.

Sharps injuries and bites

If skin is broken as a result of a used needle injury or bite, encourage the wound to bleed/wash thoroughly using soap and water. Contact GP or occupational health or go to A&E immediately. Ensure local policy is in place for staff to follow. Contact the Duty Room for advice, if unsure.

Animals

Animals may carry infections, so wash hands after handling animals. Health and Safety Executive for Northern Ireland (HSENI) guidelines for protecting the health and safety of children should be followed.

Animals in school (permanent or visiting). Ensure animals' living quarters are kept clean and away from food areas. Waste should be disposed of regularly, and litter boxes not accessible to children. Children should not play with animals unsupervised. Hand-hygiene should be supervised after contact with animals and the area where visiting animals have been kept should be thoroughly cleaned after use. Veterinary advice should be sought on animal welfare and animal health issues and the suitability of the animal as a pet. Reptiles are not suitable as pets in schools and nurseries, as all species carry salmonella.

Visits to farms. For more information see <https://www.hseni.gov.uk/publications/preventing-or-controlling-ill-health-animal-contact-visitor-attractions>

Vulnerable children

Some medical conditions make children vulnerable to infections that would rarely be serious in most children. These include those being treated for leukaemia or other cancers, on high doses of steroids and with conditions that seriously reduce immunity. Schools and nurseries and childminders will normally have been made aware of such children. These children are particularly vulnerable to chickenpox, measles and parvovirus B19 and, if exposed to either of these, the parent/carer should be informed promptly and further medical advice sought. It may be advisable for these children to have additional immunisations, for example pneumococcal and influenza. This guidance is designed to give general advice to schools and childcare settings. Some vulnerable children may need further precautions to be taken, which should be discussed with the parent or carer in conjunction with their medical team and school health. Vulnerable children will have been offered COVID-19 vaccinations and booster vaccinations.

Female staff – pregnancy

If a pregnant woman develops a rash or is in direct contact with someone with a potentially infectious rash, this should be investigated by a doctor who can contact the duty room for further advice. The greatest risk to pregnant women from such infections comes from their own child(ren), rather than the workplace.

- Chickenpox can affect the pregnancy if a woman has not already had the infection. Report exposure to midwife and GP at any stage of pregnancy. The GP and antenatal carer will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.
- German measles (rubella). If a pregnant woman comes into contact with German measles she should inform her GP and antenatal carer immediately to ensure investigation. The infection may affect the developing baby if the woman is not immune and is exposed in early pregnancy.
- Slapped cheek disease (fifth disease or parvovirus B19) can occasionally affect an unborn child. If exposed early in pregnancy (before 20 weeks), inform whoever is giving antenatal care as this must be investigated promptly.
- Measles during pregnancy can result in early delivery or even loss of the baby. If a pregnant woman is exposed she should immediately inform whoever is giving antenatal care to ensure investigation.
- All female staff born after 1970 working with young children are advised to ensure they have had two doses of MMR vaccine.

*The above advice also applies to pregnant students.

Immunisations

Immunisation status should always be checked at school entry and at the time of any vaccination. Parents should be encouraged to have their child immunised and any immunisation missed or further catch-up doses organised through the child's GP.

For the most up-to-date immunisation advice and current schedule visit www.publichealth.hscni.net or the school health service can advise on the latest national immunisation schedule.

Routine childhood immunisation programme

When to immunise	Diseases vaccine protects against	How it is given
2 months old	Diphtheria, tetanus, pertussis (whooping cough), polio, Hib and hepatitis B (6 in 1) Rotavirus Meningococcal B infection	One injection Orally One injection
3 months old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B (6 in 1) Pneumococcal infection	One injection Orally
4 months old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B (6 in 1) Meningococcal B infection	One injection One injection
Just after the first birthday	Measles, mumps and rubella Pneumococcal infection Hib and meningococcal C infection Meningococcal B infection	One injection One injection One injection One injection
Every year from 2 years old up to and including Y12	Influenza	Nasal spray or injection
3 years and 4 months old	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella	One injection One injection
Girls and boys 12 to 13 years old	Conditions caused by human papillomavirus including cervical cancer (in girls) and cancers of the mouth, throat, anus and genitals (in boys and girls) and genital warts.	One injection
14 to 18 years old	Tetanus, diphtheria and polio Meningococcal ACWY	One injection One injection

This is the Immunisation Schedule as of September 2022. Children who present with certain risk factors may require additional immunisations. Always consult the most updated version of the "Green Book" for the latest immunisation schedule on www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book-the-green-book

Staff immunisations. All staff should undergo a full occupational health check prior to employment; this includes ensuring they are up to date with immunisations, including two doses of MMR.

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Tel: 0300 555 0114,
www.publichealth.hscni.net





Public Health
England



Managing **INFECTIOUS** cases of **DISEASES** in schools and other childcare settings

A practical
guide for
staff

The online guide offers information and
resources for the following:

school

Introduction to
Infection control
in schools and
childcare facilities



Prevention
and control



Outbreak
management



Managing
specific infections



Cleaning the
environment



Staff health, pet
and animal contact



Immunisation



Diarrhoea and
vomiting outbreak
action list



Exclusion table



ADVICE AND GUIDANCE

To find out more, visit www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities or bit.ly/2xiJpPZ.

Management of Infectious Disease in Schools

Below is a selection of letters to parents informing them of certain infectious diseases that may be useful for informing parents. If a case appears in your school the letters may help to provide information for parents and to allay anxiety

Sample notification letters to parents for the following conditions are available:

1. Chicken Pox
2. Hand, Foot and Mouth Disease
3. Head Lice/Nits
4. Impetigo
5. MRSA
6. Ringworm
7. Rubella (German Measles)
8. Scabies
9. Scarlet Fever
10. Slapped Cheek Syndrome (Parvovirus B19)
11. Winter Vomiting Disease (Norovirus)/General Gastroenteritis

1. CHICKENPOX

Date: _____

Dear Parent or Guardian,

There has been a case of chickenpox in your child's school and your child may have been exposed. If your child has not had chickenpox before it is quite likely that he/she will catch it.

What is chickenpox?

Chickenpox is a common childhood illness. Fever and cold symptoms are often the first signs of illness and are followed by the appearance of the typical rash. The rash starts as small pink bumps, often around the neck, ears, back and stomach. These develop a little water blister, which in turn becomes yellow and oozy and ultimately crusty as it dries. The rash spreads outwards to involve the whole body finally involving the lower arms and legs. People may have only a few spots or may be virtually covered with them. In children it is usually a relatively mild illness however occasionally complications develop.

Why should I be concerned about chickenpox?

Chickenpox can be a devastating infection in people with a seriously weakened immune system (e.g. patients with leukaemia or after organ transplantation). In adults, chickenpox is a much more significant illness than in children and there is a greater risk of complications developing. Chickenpox in pregnancy may cause severe illness and, in the early stages of pregnancy, may result in abnormalities in the baby.

What should I do now?

If your child is normally healthy, chickenpox is likely to be a relatively mild illness and no specific precautions are necessary. Symptoms usually develop 10 to 21 days after exposure. The infected person can spread infection for up to three days before the rash appears and until the last pox is crusted and dry. If your child has a weakened immune system, please contact your child's GP or hospital consultant and let them know that your child may have been exposed.

What should I do if I think my child has chickenpox?

If you suspect chickenpox, do not bring the child into a crowded surgery waiting room, as this may only spread the infection further. Contact your doctor to confirm the diagnosis. Do not use aspirin or any products that contain aspirin to control fever if your child has chicken pox, as this has been associated with the development of a rare but serious disease called Reye's syndrome.

Can my child stay in school?

Many children with chickenpox are too sick to attend school and are more comfortable at home. Children can spread the infection to others as long as there are any spots, which are not crusted and dried. Children with chickenpox should be excluded from school until scabs are dry; this is usually five to seven days after the appearance of the rash. Children with spots that are crusted and dried can safely attend school.

I am pregnant and have been exposed to a child with chickenpox. What should I do?

Most adults in Ireland are immune to chickenpox as they have had the illness in childhood. If you have not had chickenpox illness in the past and have had recent contact with chickenpox you should contact your GP, who may wish to do a blood test to check if you are immune. Chickenpox infection in pregnancy may cause more severe illness and there may be a risk to the foetus. Thank you for giving this your attention. Your GP will be able to answer any further questions that you might have about chickenpox.

2. HAND, FOOT AND MOUTH DISEASE

Dear Parent or Guardian,

Date: _____

There has been a case of hand, foot and mouth disease within your child's school and your child may have been exposed.

What is hand, foot and mouth disease?

This is a disease caused by a group of viruses which usually affects young children. It causes blisters on hands and feet, and mouth ulcers inside the cheeks and on the tongue. They may also have a sore throat and high temperature. These symptoms last for 7–10 days.

Is it dangerous?

No. All make a full recovery.

Is it the same as foot and mouth disease in cows?

No. A completely different virus causes foot and mouth disease in cows.

How is it spread?

The virus is spread by coughs and sneezes, and is also found in the faeces of infected children. Some children infected with the virus do not have symptoms but can still pass it to others.

Is there any treatment?

There is no specific treatment for hand, foot and mouth disease – it is usually a mild and self-limiting illness. If a child feels unwell paracetamol may help. Antibiotics and creams or ointments for the blisters are not effective. Children recover just as quickly without them.

What is the incubation period?

Symptoms start 3-5 days after exposure to the virus.

How long are children infectious?

Children who are ill are infectious. Also they may carry the virus in their faeces for many weeks after they have recovered and so can continue to pass on infection.

How long should children stay away from school?

Children who are unwell should be kept off school until they are feeling better. Keeping children off school for longer than this is unlikely to stop the virus spreading. There may be other children in the school who appear well but are spreading the virus.

How can spread be prevented?

Since the virus is found in faeces, scrupulous attention must always be paid to hand washing after using the toilet.

Can you catch it more than once?

Yes, but children who are ill during an outbreak at school or nursery are unlikely to get it again during the same outbreak. Thank you for giving this your attention. Your GP will be able to answer any further questions that you might have about hand, foot and mouth disease.

3. HEADLICE/NITS

Dear Parent or Guardian,

Date: _____

There has been a case of headlice in your child's school and your child may have been exposed.

What are headlice?

Headlice are little insects with moving legs. They are often not much bigger than a pin head, but may be as big as a sesame seed (the seeds on burger buns). They live on, or very close to, the scalp and don't wander far down the hair shaft for very long. They can only live on humans; you cannot catch them from animals.

What are nits?

Nits are not the same thing as lice. Nits are egg cases laid by lice, stuck on to hair shafts. They are smaller than a pin head and pearly white. If you have nits it doesn't always mean that you have headlice. When you get rid of all the lice, the nits will stay stuck to the hair until it grows out.

How are they spread?

Anyone can pick up headlice. They are most common among young children as they often put heads together during play allowing the lice walk from one head to the next. Headlice do not reflect standards of hygiene. They are just as willing to live in clean or dirty hair.

Can you stop them?

The best way is for families to learn how to check their own heads. This way they find any lice before they have a chance to breed. They can then treat them and stop them being passed round the family. The way to check someone's head is called "detection combing". This should be done regularly and in the case of a confirmed infection in one family member, the other members of the household should carry out "detection combing" twice weekly for one week.

How do I do detection combing?

You need a plastic detection comb, good lighting and an ordinary comb.

- Wash the hair well, then dry it with a towel. The hair should be damp, not dripping. A small amount of conditioner may help if the hair is tangled.
- Make sure there is good light, daylight is best.
- Comb the hair with an ordinary comb.
- Start with the teeth of the detection comb touching the skin of the scalp at the top of the head.
- Draw the comb carefully towards the edge of the hair.
- Look carefully at the teeth of the comb in good light.
- If there are headlice, you will find one or more lice on the teeth of the comb. A magnifying glass may be useful in identifying lice.
- Do this over and over again from the top of the head to the edge of the hair in all directions, working round the head.
- Do this for several minutes. It takes 10 to 15 minutes to do it properly for each head.

Who needs treatment?

Only treat those who have living, moving lice. If more than one family member has lice, treat all at the same time.

How do I treat them?

A headlice lotion (not shampoo) should be used. Ask your local pharmacist, public health nurse or GP which lotion to use, and how long to leave it on. Follow the instructions that come with the particular product.

- Repeat treatment again seven days later, in the same way, with the same lotion.
- Check all heads a day or two after the second treatment.

If you still find living, moving lice, ask your public health nurse or GP for advice.

4. IMPETIGO

Dear Parent or Guardian,

Date: _____

There has been a suspected case of impetigo in your child's school and your child may have been exposed. Although impetigo is not usually a serious condition, it is very infectious, and if not treated promptly complications may occasionally occur.

What is impetigo?

Impetigo is a bacterial infection of the skin caused by the same bacteria that commonly cause sore throats i.e. group A streptococci, although it can also be caused by Staphylococcus aureus or a mixture of the two. It can cause small blisters on the skin which break and become covered with a yellow crust. Impetigo commonly affects the hands and face although it can spread to other parts of the body especially if the skin is broken.

Who catches impetigo?

Anyone can catch impetigo, but most cases occur in crowded environments e.g. in children in schools.

How is impetigo spread?

Impetigo is usually spread by direct contact with someone who is infected or indirectly by sharing towels, face cloths, clothes or toys that have been used by someone who is infected. The bacteria are present in the skin lesions. Secretions from the rash/sores are infectious. Hands that touch the rash/sores can become contaminated and can pass the infection to other body sites or other people.

How is impetigo diagnosed?

Impetigo can usually be diagnosed by simply looking at it. If you suspect your child has impetigo, you should attend your GP for confirmation and treatment.

How is impetigo treated?

Your GP will usually prescribe an antibiotic ointment. Sometimes, if the rash is more extensive or is spreading rapidly, an oral antibiotic will be needed.

Should children with impetigo be excluded from school?

Children diagnosed with impetigo should remain out of school until the sores have stopped blistering or crusting, or until 24 hours after starting appropriate treatment.

How can you stop the spread of impetigo?

- All cases of impetigo should be treated appropriately and promptly.
- Good personal hygiene is important in preventing infection. Children and household members should be encouraged to wash their hands frequently especially after touching the rash/sores or applying skin ointment. Fingernails should be kept short.
- Children with impetigo should be discouraged from touching the sores/rash to prevent further spread.
- Cuts and scratches should be kept clean and any conditions that involve broken skin, e.g. eczema, should be treated promptly.
- Towels and face cloths should not be shared.

Your GP will be able to answer any further questions you may have on impetigo.

5. MRSA (METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS)

Dear Parent or Guardian,

Date: _____

What is MRSA?

Staphylococcus aureus is a type of bacteria (germ) that is often found on the skin and in the nose of healthy people. Most people who carry staphylococcus on their skin or in their nose (about one in three people) will not suffer any ill effects. People who carry these bacteria on their skin or in their nose without showing any signs or symptoms of infection are described as being "colonised". Methicillin-resistant Staphylococcus aureus (MRSA) is a specific type of staphylococcus that no longer responds to many commonly used antibiotics such as penicillin. Occasionally these bacteria cause infections (e.g. impetigo, boils, abscesses or infected wounds) if they enter the body through a break in the skin due to a cut, sore or surgical incision. This is most likely to occur in people who are already ill. A few people however, may develop more serious infections such as septicaemia, also known as a 'bloodstream infection', especially people who are already ill in hospital or who have long term health problems.

How is Staphylococcus aureus (including MRSA) spread?

Staphylococci (including MRSA) are usually spread from person to person on unwashed hands, particularly after having direct contact with a draining wound (e.g. cut or sore), but it can also be spread by touching items used by an infected person e.g. soiled dressings.

Should children with Staphylococcus aureus (including MRSA) be excluded from school?

Children known to carry Staphylococcus aureus (including MRSA) on the skin or in the nose do not need to be excluded from school. Children who have draining wounds or skin sores producing pus will only need to be excluded from school if the wounds cannot be covered or contained by a dressing and/or the dressing cannot be kept dry and intact.

How can you prevent spread?

The main ways to prevent infection are to wash your hands and care for wounds properly.

- Hand washing with soap and running water is the most effective way to prevent the spread of infection.
- Keep cuts and scrapes clean and covered until healed; watch for signs of infection, such as pus, redness, warmth and swelling.
- Do not share personal items e.g. towels, facecloths, flannels, bedding and clothes.
- Cover infected wounds with clean dressings.
- If a dressing needs to be changed in school, gloves should be worn by the care giver and hands should be washed before and after changing the dressing.
- Discard soiled items (e.g. dressings) in a sealed plastic bag before placing it in a domestic waste bin.

Useful information on MRSA can be found at;

<http://www.hpsc.ie/hpsc/A-Z/MicrobiologyAntimicrobialResistance/EuropeanAntimicrobialResistanceSurveillanceSystemEARSS/ReferenceandEducationalResourceMaterial/SaureusMRSA/>

6. RINGWORM

Dear Parent or Guardian,

Date: _____

There has been a case of ringworm within your child's school and your child may have been exposed.

What is ringworm?

Ringworm is a fungal infection of the skin that can affect different parts of the body. How it looks depends on where it is. On the skin it presents as a roughly circular, scaly, itchy rash. Sometimes there may be small blisters and even pus filled spots. It can involve the nails, causing them to thicken and discolour. On the scalp it often starts as a small bump, gradually spreading outwards and is associated with hair loss. On the feet there may be cracking between the toes.

What should I do now?

As ringworm spreads through skin contact or through contact with infectious skin flakes shed into clothes or the environment, it can easily spread within a school. It is important that you check your child's skin and hair for the presence of any suspicious lesion.

What should I do if I think my child has ringworm?

If you see any suspicious areas on your child's skin or scalp, bring the child to your GP. The GP will be able to decide by looking at it directly, by examining it with special light, or by examining some skin cells under the microscope whether or not it is ringworm. Once the diagnosis is made treatment can be given. It is important that the rest of the family are checked for ringworm. Also check and treat symptomatic pets.

Can my child stay in school?

Yes. However, to prevent the spread of infection to others it is important that the affected child receives appropriate treatment.

Thank you for giving this your attention. Your GP will be able to answer any further questions that you might have about ringworm.

7. RUBELLA (GERMAN MEASLES)

Dear Parent or Guardian,

Date: _____

There has been a case of rubella within your child's school and your child may have been exposed.

MMR (measles, mumps, rubella) vaccine is given at 12 months of age and as a preschool booster at 4-5 years. If your child received two MMR vaccines the chance of him/her developing rubella is extremely low. If, however, your child has not been vaccinated then it is quite possible that he/she might get rubella.

What is rubella?

Rubella is a mild viral illness that causes little problem for children. In childhood it causes a mild flu like illness with mild swelling of the glands, particularly those at the back of the neck, and a fine pinkish red rash. In addition adults can develop painful joints (arthritis).

Why should I be concerned about rubella?

If a pregnant woman develops rubella in the early stages of pregnancy her unborn baby may also be infected and the consequences can be devastating. Rubella infection in the unborn can cause severe developmental delay, eye defects, hearing problems and a wide variety of congenital abnormalities.

Who gets rubella?

Anyone who is not immune to it and who has contact with someone with rubella can get rubella. People who have either received rubella vaccine (part of the MMR) or who have had rubella should be immune. A simple blood test can tell whether or not you are immune to it. As many viral illnesses are similar to rubella, and are often mistaken for it, you cannot consider yourself immune unless you have had the blood test or been vaccinated with the rubella or MMR vaccine.

What should I do now?

If you and your child have received rubella vaccine or you have been tested and know that you are immune, there is no need for concern. If your child has not received MMR vaccine, bring them to your GP for vaccination. The vaccine will not protect them if they have been exposed this time, but it will protect them from future exposures. If you are pregnant or likely to become pregnant, please contact your GP and find out whether or not you are immune to rubella. If you are not immune (and are not pregnant) you should contact your GP and arrange to get the vaccine.

What should I do if I think my child has rubella?

If your child develops a flu-like illness, with a fine red rash and swelling of the glands behind the ears, arrange for your doctor to see the child. He will be able to tell you if it looks like rubella and will advise you what to do. If you suspect rubella, do not bring your child into a crowded surgery waiting room, as this may only spread the infection further. There is no treatment for rubella and symptoms resolve over a few days.

Can my child stay in school?

Children with rubella must stay at home until at least seven days after the appearance of the rash.

Thank you for giving this your attention. Your GP will be able to answer any further questions that you might have about rubella and the MMR vaccine.

8. SCABIES

Dear Parent or Guardian,

Date: _____

There has been a case of scabies within your child's school and your child may have been exposed. We are bringing this to your attention because scabies can spread rapidly unless all affected children are promptly treated.

What is scabies?

Scabies is an infestation of the skin with a tiny mite smaller than a pinhead. The mites burrow anywhere in the skin, mostly on hands, and cannot be seen. The rash is caused by the body's reaction to the mite and the scratching that occurs.

How could my child get scabies?

Anyone can get scabies. The mite passes from person to person through skin contact. Scabies is unlikely to be caught by short contact such as shaking hands. Longer contact is needed but could be as little as 5 to 10 minutes. Children playing together are especially likely to pass it from one to the other. The itching may occur anytime from two to eight weeks after catching the mites, so mites can pass to someone else before the rash appears.

How will I know if my child has scabies?

If your child develops an itchy rash bring them to their doctor.

What should I do if my child has scabies?

A variety of special lotions and creams that kill mites are available at the pharmacy. It is best to see your doctor first to be sure that it is scabies. It is important to follow the instructions that come with the lotion carefully, as there are a number of different preparations available. As spread within households is common, it is a good idea to treat all family members at the same time even if there are no symptoms.

Thank you for giving this your attention. Your GP or pharmacist will be able to answer any further questions that you might have concerning scabies and the preparations available to treat it.

9. SCARLET FEVER

Dear Parent or Guardian,

Date: _____

There has been a case of scarlet fever within your child's school and your child may have been exposed.

What is scarlet fever?

Scarlet fever is a scattered red rash and high temperature caused by bacteria (Group A streptococci). Occasionally these bacteria can cause kidney or heart complications. Prompt treatment with an antibiotic usually prevents these complications. Treatment will also prevent spread to others.

What are the symptoms of scarlet fever?

A scattered red rash that is often most marked in the creases of the joints and over the stomach. It usually blanches (goes white) when pressed on. The skin may feel rough to the touch, sometimes described as feeling like sandpaper. Someone with scarlet fever will have evidence of a streptococcal infection somewhere, usually in the throat or sometimes in the skin.

What should I do if I think my child has it?

If your child develops any of these symptoms bring him/her to your GP for examination. Tell the doctor that another child in the school has scarlet fever.

If my child has scarlet fever what should I do?

The doctor will prescribe an antibiotic for your child. It is important that your child takes the full course of medicine.

Can my child stay in school?

Your child can return to school when he/she is well and has finished one full day of antibiotic treatment.

What can I do to prevent spread of infection at home?

The bacteria are spread through contact with nose and mouth secretions so:

- Wash hands thoroughly after wiping nose.
- Wash hands thoroughly before preparing food.
- Wash dishes well in hot soapy water.
- Do not share cups, straws, spoons, eating utensils etc.
- Do not share toothbrushes.

Thank you for giving this your attention. Your GP will be able to answer any further questions that you might have regarding Scarlet Fever.

10. SLAPPED CHEEK SYNDROME (PARVOVIRUS B19)

Dear Parent or Guardian,

Date: _____

There has been a case of slapped cheek syndrome (sometimes called Fifth Disease) which is caused by the parvovirus B19 virus in your child's school and your child may have been exposed.

What is "Slapped Cheek Syndrome"?

It is a mild rash illness that occurs most commonly in children. The ill child typically has a 'slapped-cheek' rash on the face and a lacy red rash on the trunk and limbs. Occasionally, the rash may itch. An ill child may feel unwell and have a low-grade fever or a 'cold' a few days before the rash breaks out. The child is usually not very ill, and the rash resolves in 7 to 10 days.

Can adults get parvovirus B19 infection?

Yes, they can. An adult who is not immune can be infected with parvovirus B19 and either have no symptoms or develop the typical rash of slapped cheek syndrome, joint pain or swelling, or both. The joint pain and swelling usually resolve in a week or two, but may last longer. However, most adults have previously been infected with parvovirus B19 and have developed life-long immunity to the virus and cannot become infected again.

Is parvovirus B19 infectious?

Yes. A person infected with parvovirus B19 is infectious during the early part of the illness, before the rash appears. By the time a child has the characteristic 'slapped cheek' rash he/she is probably no longer contagious.

How does someone get infected with parvovirus B19?

Parvovirus B19 has been found in the respiratory secretions (e.g. saliva, sputum, or nasal mucus) of infected persons before the onset of a rash, when they appear to "just have a cold". The virus is probably spread from person to person by direct contact with those secretions, such as sharing cutlery, cups, drinks, drinking glasses etc.

Is parvovirus B19 infection serious?

Parvovirus B19 is usually a mild illness that resolves on its own. Parvovirus B19 infection may cause a serious illness in persons with chronic red blood cell disorders (e.g. sickle cell anaemia or spherocytosis) or a weakened immune system. Rarely, serious complications may develop from parvovirus B19 infection during early pregnancy.

Can parvovirus B19 infection be prevented?

There is no vaccine or medicine that prevents parvovirus B19 infection. Frequent hand washing is recommended to decrease the chance of becoming infected. People should also avoid sharing cutlery, cups, drinks, drinking glasses etc.

Should children with parvovirus be excluded from school?

Excluding pupils with slapped cheek syndrome from school is not likely to prevent the spread of the virus. People are infectious before they develop the rash and it becomes clear that they have slapped cheek syndrome. Cases of slapped cheek syndrome in a school most commonly happen when the infection is spreading in the community.

I am pregnant and have been exposed to a child with parvovirus B19. What should I do?

You should contact your doctor, who may wish to do a blood test. Usually, there is no serious complication for a pregnant woman or her baby if exposed to a person with slapped cheek syndrome. Most women are already immune to parvovirus B19, and these women and their babies are protected from infection and illness. Even if a woman is susceptible and gets infected with parvovirus B19, she usually experiences only a mild illness. Likewise, her unborn baby usually does not develop any problems due to parvovirus B19 infection. However, sometimes parvovirus B19 infection may cause miscarriage or severe anaemia in the unborn baby. There is no evidence that parvovirus B19 infection causes birth defects or developmental delay.

The school should be notified of all pupil absence through the [link](#) on the school website.

11. NOROVIRUS (Winter Vomiting Disease)

Dear Parent or Guardian,

Date: _____

There have been cases of norovirus (winter vomiting disease) within your child's school and your child may have been exposed.

What is winter vomiting disease?

A virus known as norovirus causes winter vomiting disease. The virus usually causes short-lasting outbreaks but is very contagious. The infection has caused many outbreaks in the community and in health care settings in recent years.

What are the symptoms of winter vomiting disease?

Symptoms can include:

- Nausea (often sudden onset)
- Vomiting (often projectile)
- Crampy abdominal pain
- Watery diarrhoea
- High temperature chills and muscle aches.

Symptoms begin around 12 to 48 hours after becoming infected. The illness is usually brief, with symptoms lasting only about 1-2 days. However, illness may be prolonged in some people (usually the very young or elderly). In more severe cases it may cause dehydration and require hospital treatment. If you have any specific concerns about your child you should contact your GP.

How is winter vomiting disease spread?

People can become infected with the virus in several ways, including:

- Contact with an infected person, especially contact with vomit or faeces.
- Contact with contaminated surfaces or objects and then touching eyes, nose or mouth.
- Consuming contaminated food or water.

What can be done to prevent infection?

It is often impossible to prevent infection; however, taking good hygiene measures around someone who is infected can decrease your chance of getting infected.

- Wash hands frequently including before eating or preparing food and after toilet use.
- Thoroughly clean and disinfect contaminated surfaces immediately after an episode of vomiting or diarrhoea by using a bleach-based household cleaner.
- Flush or discard any vomit and/or faeces in the toilet and make sure that the surrounding area is kept clean.

Are noroviruses contagious?

Noroviruses are very contagious and can spread easily from person to person. Both faeces and vomit of an infected person contain the virus and are infectious. People infected with norovirus are contagious from the moment they begin feeling ill to two to three days after recovery. Some people may be contagious for as long as two weeks after recovery. It is important for people to use good hand washing and other hygienic practices after they have recently recovered from a norovirus infection. In addition, noroviruses are very resilient and can survive in the environment (on surfaces etc.) for a number of weeks. Therefore it is important that surfaces and objects that may have become contaminated are cleaned thoroughly.

Can my child stay in school?

It is extremely important that people who have been ill with vomiting or diarrhoea should remain off school or work while symptomatic and for two full days after their last episode of vomiting or diarrhoea.

Thank you for giving this your attention. Your GP will be able to answer any further questions that you might have about winter vomiting disease.

The school should be notified of all pupil absence through the [link](#) on the school website.