

Local Health Department Guidelines for the Epidemiological Investigation and Control of Pertussis (Whooping Cough)

Maryland Department of Health and Mental Hygiene
Infectious Disease and Environmental Health Administration
Center for Immunization
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Introduction

Pertussis is an acute respiratory illness caused by a gram-negative bacterium, *Bordetella pertussis*. Pertussis is endemic in the United States and continues to cause significant morbidity, especially in young infants and unimmunized or under-immunized adolescents and adults. A major goal of pertussis prevention efforts is to prevent infection in infants who have higher rates of complications and deaths.

This document was written to provide guidance on the investigation of pertussis cases and outbreaks. The recommendations in this document are intended to provide general guidance. Pertussis incidents should be evaluated on an individual basis, with the consultation of local and state infection control staff if needed, to determine the appropriate steps for pertussis prevention and control.

Questions regarding these guidelines can be directed to:

Center for Immunization
Maryland Department of Health and Mental Hygiene
201 W. Preston St.
Baltimore, MD 21201
(410) 767-6679

Disease Description

Mode of transmission: Pertussis is highly contagious. Transmission occurs via the respiratory route, when infectious respiratory droplets which have been expelled into the air through coughing are breathed in by close contacts. Transmission can also occur through direct contact with respiratory secretions. Humans are the only known reservoir for pertussis.

Epidemiology: The epidemiologic pattern of pertussis is cyclical, with peaks occurring every 3-4 years. Vaccination is the most effective way to prevent infection and limit the size of outbreaks. However, neither vaccination nor natural infection provides life-long immunity to pertussis. Waning immunity following vaccination as well as lack of vaccination coverage in communities contributes to the occurrence of pertussis cases and outbreaks.

Incubation Period: The incubation period of pertussis is 7-10 days (range: 4-21 days).

Clinical Manifestation: Pertussis illness begins with mild respiratory symptoms similar to the common cold, such as runny nose, sneezing, congestion and/or mild coughing, coryza, which is the catarrhal stage. Coughing gradually becomes more severe and frequent, and in the paroxysmal stage, paroxysmal coughing (bursts of rapid coughing), violent coughing fits followed by an inspiratory “whoop”, and/or post-tussive vomiting can occur. In the convalescent stage, recovery is gradual. The cough becomes less paroxysmal and disappears in 2 to 3 weeks.

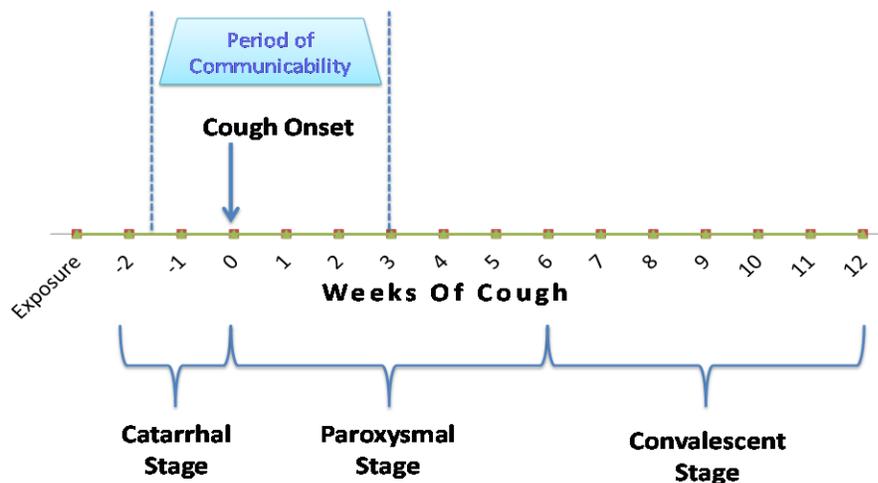
Pertussis may be difficult to diagnose in its early stages since symptoms resemble those of a common cold or other respiratory infection. Illness may also be difficult to recognize in infants under 6 months of age since they may have atypical symptoms such as apnea, gasping and absence of whoop. Symptoms are often milder in adolescents, adults and individuals who have received pertussis vaccine.

Pertussis illness consists of 3 stages: catarrhal, paroxysmal and convalescent. The entire course of illness is typically 6-10 weeks, although young children and infants may take longer to recover fully.



Stage	Catarrhal	Paroxysmal	Convalescent
Duration	1-2 weeks	2-6 weeks	Weeks to months
Symptoms	<p>Symptoms similar to minor respiratory tract illness:</p> <p>Nasal congestion, runny nose, sneezing, minimal or no fever, mild sore-throat, intermittent dry cough</p> <p>Infants may have atypical symptoms.</p>	<p>Paroxysmal coughing (succession of coughs) terminating with inspiratory “whoop”.</p> <p>Post-tussive vomiting</p>	<p>Paroxysms gradually decrease in frequency and intensity, but occasional coughing bouts may occur.</p> <p>Non-paroxysmal coughs persist for 2-6 weeks or longer</p>

Pertussis Disease Progression



Click here to hear pertussis: [Sound of Pertussis Link](#)

The most common complication from pertussis illness is secondary bacterial pneumonia. Infants are at the highest risk for pertussis-associated complications, hospitalizations and deaths. Infants are at higher risk for neurologic complications, such as seizures and encephalopathy, stemming from reduced oxygen to the brain after prolonged and frequent coughing fits. Some of the direct effects of violent coughing include: urinary incontinence, hernias, rib fracture, pneumothorax, epistaxis (nose bleed), subdural hematoma, and rectal prolapse.

Communicability Period: A person infected with pertussis is:

- Infectious 2 weeks before to 3 weeks after onset of cough
- Most infectious during the catarrhal (early) stage and during the first 2 weeks after onset of cough
- No longer infectious after 5 days of treatment with an antibiotic effective against pertussis

Even though adolescents and adults may have milder symptoms, they can still transmit the disease to others. Oftentimes, an adult is the source of infection for under-immunized or unimmunized infants and children.

CDC Surveillance Case Classification and Definitions

CDC surveillance case classification of pertussis

1) Probable:

- 1) Cough lasting ≥ 2 weeks
AND
- 2) Paroxysms of coughing, inspiratory “whoop” or post-tussive vomiting
AND
- 3) No laboratory confirmation
AND
- 4) No epidemiologic linkage to a lab-confirmed case.

2) Confirmed:

- 1) Acute cough illness of any duration, with isolation of *B. pertussis* from a clinical specimen

OR

- 2) Cough lasting ≥ 2 weeks with at least one of the following symptoms: paroxysms of coughing, inspiratory “whoop” or post-tussive vomiting AND a positive PCR result

OR

- 3) Illness lasting ≥ 2 weeks with at least one of the following symptoms: paroxysms of coughing, inspiratory “whoop” or post-tussive vomiting AND contact with a lab-confirmed case of pertussis.

The clinical case definition above is appropriate for endemic or sporadic cases. In outbreak settings, a case may be defined differently (see outbreak section below)

The most up-to-date CDC case definitions can be found at the following website:
http://www.cdc.gov/osels/ph_surveillance/nndss/casedef/case_definitions.htm.

3) Outbreak: An outbreak of pertussis is defined as:

≥ 2 laboratory confirmed (by culture or PCR) cases clustered in time (e.g. within 42 days of each other) and space (e.g. in one building) where transmission is suspected to have occurred in that setting (e.g. nosocomial transmission in a hospital)

OR

1 laboratory confirmed (by culture or PCR) case AND 1 epi-linked case with cough illness lasting ≥ 2 weeks with one of the following: paroxysms of cough, inspiratory whoop, or post-tussive vomiting.

Definitions

Parapertussis: Parapertussis, which is a milder pertussis-like illness, is caused by *Bordetella parapertussis*. Parapertussis is not a reportable condition. Public health investigation of parapertussis is not required.

Testing/Laboratory Diagnosis

Culture and PCR are the recommended tests for laboratory diagnosis of pertussis. Both tests should be done for all suspected pertussis cases. These tests are described below and summarized in Table 1.

Currently, culture is the gold standard for diagnosing pertussis as it is 100% specific for *B. pertussis*. Since pertussis infection may occur concurrently with other illnesses, and since symptoms of pertussis are similar to symptoms of other respiratory infections, isolation of *B. pertussis* is important to make an accurate diagnosis, especially in outbreak situations.

To enhance the possibility of detecting *B. pertussis* in culture, specimen collection should occur as soon as possible and no later than 3 to 4 weeks of illness. The chances of obtaining a positive culture lessen progressively over the course of illness.

Since culture results take 1-2 weeks, PCR results (which are available in 1-2 days) are most helpful for usage by practitioners, in conjunction with clinical symptom evaluation, to make a preliminary diagnosis and to make appropriate treatment and public health recommendations.

PCR has greater sensitivity than culture and produces a greater number of false positive results. However, *B. pertussis* does not need to be viable in order to be detected by PCR so PCR is less affected by antibiotic therapy as compared to culture.

DFA and serologic testing should ***not*** be used as methods for laboratory diagnosis of pertussis. Direct fluorescent antibody (DFA) testing has a low sensitivity and is no longer recommended. Commercial serologic tests can detect the presence of IgM and/or IgG antibodies. However, since vaccination can induce the production of IgM and IgG antibodies, serologic testing is not useful for differentiating exposure to pertussis from vaccination and from natural infection. If vaccination occurred greater than 2 years prior to specimen collection, a positive IgG may indicate recent infection with pertussis. As of March 2011, positive serology results from a private laboratory are not confirmatory for the purpose or reporting according to the CDC.

Recommended steps for testing:

- 1) At first contact with a suspected case of pertussis, obtain a specimen from the posterior nasopharynx for PCR and culture testing (see Figure 1). Proper PPE (surgical mask) should be donned during collection. Ideally, specimen should be obtained as soon as possible (within 3 weeks of cough onset) and prior to the patient receiving antibiotic treatment. PCR specimens can still be obtained if the case has been on antibiotics for up to 5 days.

Follow specimen collection and handling procedures carefully to ensure a viable specimen and accurate results. The specimen for culture should be obtained using a Dacron or calcium aginate swab. Culture specimens can also be obtained by aspiration. The specimen for PCR should be obtained using a Dacron swab or nasal wash. Calcium aginate swabs should *not* be used to obtain PCR specimens. Cotton swabs should ***not*** be used for the collection of PCR or culture specimens.

- 2) After obtaining a nasopharyngeal specimen from the patient, the specimen should be placed in a transport medium such as Regan-Lowe agar or Bordet-Gengou medium, and transported to a laboratory facility for testing. Best results are obtained by transporting specimen at room temperature the same day taken. Cooled transport of the specimen significantly decreases the number of bacteria.

Figure 1: Proper technique for obtaining a nasopharyngeal specimen for isolation of *Bordetella pertussis*

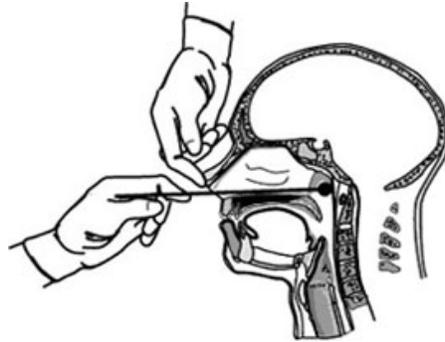


Image: Manual for the Surveillance of Vaccine-Preventable Diseases, 4th ed., 2008

Interpretation of results:

A false negative **culture** result may be obtained if:

- a) the specimen for the culture is taken more than 1-2 weeks after cough onset
- b) the patient is taking antibiotics
- c) the patient has been vaccinated for pertussis
- d) the specimen was not collected, handled or processed properly.

Table 1: Laboratory Testing for Pertussis – Culture and PCR

	Culture	PCR
Time of specimen collection	Ideally, within 2 weeks of cough onset	Ideally, within 3 weeks of cough onset
Site of specimen collection	Posterior nasopharynx (not throat)	Posterior nasopharynx (not throat)
Method of collection	1) aspiration, or 2) Dacron swab, or 3) Calcium alginate swab	1) nasal wash, or 2) Dacron swab
Time to results	1-2 weeks	1-2 days

Benefits	100% specific for <i>B. pertussis</i> ; the “gold standard” for pertussis testing	Rapid results, increased clinical usefulness
Limitations	Slow processing time (up to 2 weeks); improper specimen collection, handling and isolation techniques can affect yield of culture; limited clinical usefulness; less likely to be positive if specimen is collected more than 2 weeks after cough onset	High rates of false positive results, especially in previously immunized patients Less affected by antibiotic therapy than Culture

Treatment

Treatment of pertussis illness is important for disease control, and may also lessen the severity of symptoms if administered early in the course of illness. Antibiotics administered during the catarrhal stage, before the onset of paroxysmal coughing, may shorten the intensity or duration of disease. Initiating antibiotics after the catarrhal stage will not affect the progression of the disease but is recommended for symptomatic patients to limit the spread of illness to others. Antibiotics eliminate the shedding of infectious agents from secretions and reduce the communicability period to 5 days after the onset of treatment. Once antibiotic treatment has been initiated, the patient should be isolated and should follow droplet precautions for 5 days to limit the spread of disease to others.

The CDC recommends three antibiotics for the treatment of pertussis: azithromycin, erythromycin and clarithromycin. Azithromycin is the most commonly used antibiotic for treating pertussis, and involves one dose a day for 5 days. Trimethoprim-sulfamethoxazole (TMP-SMZ) may be used if antibiotic-resistance is suspected; however, resistance of *Bordetella pertussis* to antibiotics is rare. TMP-SMZ may also be used if the use of other antibiotics is contraindicated. Cases who are younger than 6 months of age, are pregnant, or immunocompromised, should consult in further detail with their physician about the most appropriate treatment.

Prophylaxis

Antibiotics can also be used as chemoprophylaxis for individuals who may have been exposed to pertussis. The need for chemoprophylaxis can be determined based on an evaluation of the source of pertussis, degree and type of exposure, as well as presentation of symptoms of pertussis.

In November 2013, the CDC revised the prophylaxis guidelines. While antibiotics may prevent pertussis disease if given prior to symptom onset, there are no data to indicate that widespread use of post exposure prophylaxis (PEP) among contacts effectively controls or limits the scope of pertussis outbreaks. CDC is also engaged in actively promoting the judicious use of antibiotics among healthcare providers and parents. **Given these considerations, CDC supports targeting PEP to persons at high risk of developing severe pertussis and to persons who will have close contact with those at high risk of developing severe pertussis.** Accordingly, CDC supports the following:

- Providing PEP to **all asymptomatic household contacts** of a pertussis case within 21 days of onset of cough in the index patient
- Providing PEP to persons within 21 days of exposure to an infectious pertussis-case patient who are at high risk of severe illness or who have close contact with a person at high-risk. These include:
 - Infants and women in their third trimester of pregnancy
 - All persons with pre-existing health conditions that may be exacerbated by a pertussis infection (e.g., immunocompromised persons, persons with moderate to severe medically treated asthma)
 - Contacts who themselves have close contact with either infants <12 months, pregnant women, or individuals with pre-existing health conditions at risk for severe illness or complications.
 - All contacts in high risk settings that include infants aged <12 months or women in the third trimester of pregnancy (e.g., neonatal intensive care units, childcare settings, maternity wards)
- A broader use of PEP in limited closed settings, when the number of identified cases is small, and when a community-wide outbreak is not ongoing; however, when continued transmission of pertussis is evident, multiple rounds of antibiotics would not be recommended. Rather than repeating a course of antibiotics, contacts should be monitored for onset of signs and symptoms of pertussis for 21 days.

Prophylaxis of contacts identified above is recommended *regardless of age and vaccination status*. Contacts who are younger than 6 months of age should consult in further detail with their physician about the most appropriate steps for prophylaxis and follow-up.

Prevention/Vaccination

Vaccination remains the most effective way to prevent pertussis infection. Children should get 5 doses of DTaP, one dose at each of the following ages: 2, 4, 6, and 15-18 months and 4-6 years. Adolescents 11-18 years of age (preferably at age 11-12 years) and adults 19 through 64 years of age should receive a single dose of Tdap.

However, neither natural infection nor vaccination confers lifelong immunity against pertussis. Antibodies from natural infection wane after approximately 7 years, and although reinfection is

rare and usually results in mild symptoms, it is possible for individuals to be infected with pertussis more than once. Immunity from childhood DTaP vaccination typically wanes by adolescence. As a result, the CDC recommends that adolescents and adults obtain a one-time Tdap booster dose. Individuals who are not up-to-date on their booster shots are at increased risk for pertussis infection.

In October 2010, the Advisory Committee on Immunization Practices (ACIP) expanded the use of Tdap to include the following recommendations: 1) use of Tdap regardless of interval between the last tetanus or tetanus-toxoid containing vaccine, 2) use of Tdap in adults over the age of 65 who have close contact with infants, and 3) use of Tdap in undervaccinated children aged 7 to 10 years.

In October 2012, the ACIP voted to recommend the use of Tdap during every pregnancy. Health care personnel should administer a dose of Tdap during each pregnancy, irrespective of the patient's prior history of receiving Tdap in order to maximize the maternal antibody response and passive antibody transfer to the infant.

It is especially important for healthcare workers and others who work closely with children, pregnant women and immunocompromised individuals to be up-to-date on their pertussis immunizations.

Case/Outbreak Investigation

When a patient is suspected of having pertussis, a case investigation should be started immediately. Timely and thorough case investigation should: confirm the patient's diagnosis; ensure appropriate medical follow-up for affected persons; identify the source of infection; locate persons who may have been exposed; and isolate potentially infectious persons to prevent transmission of illness in the community.

Information about all cases and contacts can generally be gathered by interviewing the patients and/or their healthcare providers. Additional information can be obtained by reviewing laboratory and medical records, as well as reports of immunization history. Information obtained during case investigations should be documented thoroughly on case report forms and/or patient charts.

Recommended case investigation procedures:

(Refer to *Special Settings* Section for additional guidance on case investigation procedures relevant to schools, hospitals, and settings where close contact may facilitate transmission of pertussis.)

1) Confirm pertussis diagnosis/Initiate pertussis control measures

- Obtain specimen for lab testing if patient is experiencing clinical symptoms of pertussis (Refer to *Testing/Laboratory Diagnosis* Section for details)

- Provide treatment for pertussis (Refer to *Treatment* Section for additional information)
- Symptomatic case-patient should be isolated for the entire communicability period (21 days following cough onset) or until 5 days of antibiotic treatment have been completed.

2) Interview the case-patient and identify source of infection

- Interview patient about contact with other known pertussis cases or persons with symptoms of pertussis.
- Utilize the CDC Pertussis Surveillance Worksheet (attached) to guide the interview and collect other relevant information (i.e. demographics, clinical details, vaccine history, etc.).

3) Identify exposed persons

Initiate a contact investigation to identify persons who may have been exposed to pertussis through contact with the case-patient.

- Interview the case-patient regarding contact with others during his/her infectious period (2 weeks before to 3 weeks after cough onset)
- If the case-patient reports travel (e.g. via plane) during his/her infectious period, contact staff at Maryland Department of Health and Mental Hygiene Center for Immunization for assistance in identifying passengers and persons in other jurisdictions/locations who may need to be contacted.
- Obtain and document immunization histories for case-patient and all contacts.
- All symptomatic contacts should be tested for pertussis and followed as suspected pertussis cases.

4) Initiate pertussis control measures

Evaluate the need for post-exposure prophylaxis in individuals who were exposed to pertussis. Identification and vaccination of household contacts can occur immediately and should not be delayed because of pending laboratory results. However, waiting for laboratory confirmation of pertussis infection prior to vaccination and prophylaxis of non-household high risk contacts may be reasonable; nevertheless, this should be evaluated on a case-by-case basis.

- Provide post-exposure prophylaxis to exposed high risk persons as defined above (Refer to *Prophylaxis* Section for additional information) . Prophylaxis of all high risk contacts of a confirmed pertussis case, including household contacts, is recommended, regardless of age and vaccination status.
- Symptomatic contacts should be tested and isolated for the entire communicability period or until 5 days of antibiotic treatment has been completed.
- Provide DTaP or Tdap immunization, according to age-appropriate recommendations, to individuals with incomplete immunization. Although

vaccination after exposure has not been proven to reduce chances of infection or lessen severity of symptoms, vaccination is important to prevent infection during subsequent exposures.

- During an outbreak, asymptomatic, exposed close contacts who decline prophylaxis for pertussis may be quarantined and monitored for the development of symptoms consistent with pertussis for 21 days after last contact with the infected person. Consult with DHMH.

5) Conduct surveillance

Active surveillance should be maintained for at least 2 incubation periods (42 days) after the last reported confirmed case to ensure that all cases are identified.

Special Settings

In addition to the recommended steps for case investigation described above, the following pertussis control measures should be conducted for cases and outbreaks occurring in settings where pertussis can be transmitted easily due to crowding and/or close contact of individuals.

1) Schools and Childcare Centers

- Assess immunization status of staff and students.
- Provide age-appropriate immunizations to staff and students with no immunity to pertussis.
- Students and staff with symptoms of pertussis should be treated and excluded from school until they have completed 5 days of antibiotic treatment.
- Persons who are not treated should be considered for exclusion from school for 21 days after last contact with the infected person. Consult with DHMH.
- Request that the school notify parents/guardians that a pertussis case has been identified in the school. A letter and pertussis fact sheet should be sent to each parent/guardian.

2) Healthcare Settings

- All healthcare workers in high risk settings that include infants <12 months or women in the third trimester of pregnancy and have had unprotected exposure to a confirmed case of pertussis should receive post-exposure prophylaxis regardless of their vaccination status.
- Staff with symptoms of pertussis should be treated and excluded from work until they have completed 5 days of antibiotic treatment.
- Healthcare workers who decline recommended prophylaxis should be excluded for 21 days from last exposure.
- Assess immunization status of all staff, including persons involved in direct patient care (e.g. nurses, physicians, phlebotomists) as well as persons who work in the patient care setting (e.g. clerical staff, front office staff, technicians).
- Provide age-appropriate immunizations to staff with no immunity to pertussis.

Reporting

All suspected pertussis cases must be reported to staff at the Maryland Department of Health and Mental Hygiene Center for Immunization within 24 hours after initial notification. All case investigations should be promptly entered into NEDSS (National Electronic Disease Surveillance System) and the information reviewed for completeness and accuracy. All possible outbreaks should be reported to DHMH.

Table 1: Summary of information to collect during case investigation

Type of Information	Information to be collected and reported
Demographic	Name Address Date of birth Sex Race/Ethnicity Country of birth Reporting source Jurisdiction Date reported
Clinical	Pre-existing medical conditions Medications Date of cough onset Duration of cough Other symptoms Hospitalizations Complications
Laboratory information	Virus isolation test dates and results, if applicable PCR test dates and results, if applicable
Epidemiologic	Transmission setting Source of transmission Vaccination status of source patient
Vaccination Status	Number of doses of pertussis containing vaccine Date(s) of vaccination Type and manufacturer of vaccine Vaccine lot number If not vaccinated, reason
Outcome	Case classification Date of death, if applicable

Vaccine Adverse Events

Adverse events that occur after administration of the pertussis vaccine should be reported to the Vaccine Adverse Event Reporting System (VAERS), a passive reporting system use to monitor vaccine safety. Any clinically significant events, unexpected events following vaccination and/or events listed on the vaccine manufacturer’s package insert, should be reported to VAERS.

Adverse events may be reported by submitting a VAERS form online, by fax or by mail. Visit <http://vaers.hhs.gov> for detailed instructions on reporting.

References

American Academy of Pediatrics. Pertussis. In: *Red Book: 2009 report of the committee on infectious diseases*. 28th Ed. Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. Elk Grove, IL; American Academy of Pediatrics; 2009:504-519.

Centers for Disease Control and Prevention. Pertussis. In: *Epidemiology and prevention of vaccine-preventable diseases*. 11th ed. Atkinson W, Wolfe S, Hamborsky J, McIntyre L, eds. Washington DC: Public Health Foundation, 2009.

Centers for Disease Control and Prevention. Guidelines for the Control of Pertussis Outbreaks. Centers for Disease Control and Prevention: Atlanta, GA, 2000.

Centers for Disease Control and Prevention. Manual for the surveillance of vaccine-preventable diseases. Centers for Disease Control and Prevention, Atlanta, GA, 2012.

Centers for Disease Control and Prevention. Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis (Tdap) Vaccine from the Advisory Committee on Immunization Practices, 2010. *MMWR* 2011; 60(01);13-15.

Centers for Disease Control and Prevention. Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine (Tdap) in Pregnant Women – Advisory Committee on Immunization Practices (ACIP), 2012. *MMWR* 2013; 62 (07); 131-135.

ACIP. ACIP Provisional Recommendations for Health Care Personnel on use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine (Tdap) and use of Postexposure Antimicrobial Prophylaxis. April 2011.

<http://www.cdc.gov/vaccines/recs/provisional/downloads/use-of-Tdap-in-hcp.pdf>

Pertussis Case Definition available at:

http://www.cdc.gov/ncphi/diss/nndss/casedef/case_definitions.htm

Sample letter to parents:

Dear Parents,

We have just been notified of a case of pertussis (whooping cough) in your child's school. Pertussis is a highly contagious illness that begins with mild, cold-like symptoms including cough and runny nose. These first symptoms typically appear 7-10 days after a person is exposed. The cough typically worsens over the following weeks and becomes spasmodic. The cough may be followed by a "whooping" sound. The spasms of cough may also be followed by vomiting. Some persons with pertussis may have very mild symptoms (mild cough with no other symptoms) and may not realize that they are sick or contagious. Pertussis is most severe in infants and can cause death.

Pertussis is spread through coughing or sneezing. It can also be spread by sharing food or eating utensils with someone with pertussis.

Pertussis is treated with antibiotics. Students who have symptoms and are prescribed antibiotics for suspected pertussis can return to school following the fifth day of treatment. Without antibiotics, a person with pertussis is considered to be contagious, and can spread pertussis to others, for three weeks after the cough starts. It is important that ill students stay at home away from others (especially infants and young children) during this time.

Pertussis vaccine is administered to children in combination with diphtheria and tetanus vaccine (DTaP) in a five-dose series and protects children against whooping cough. For children 7 years or older, a Tdap booster is recommended at age 11-12 years. Please check with your health care provider to make sure your child's shots are up-to-date.

Please watch your child for any symptoms of pertussis (mild, cold-like symptoms) over the next several weeks. If you notice any of these symptoms in your child, please notify your primary care physician and the (typically, school nurse and/or county health department) at (phone number) as soon as possible.

Sincerely,