Memorandum on closure of and exclusion from school / issued jointly by the Ministry of Health and the Board of Education.

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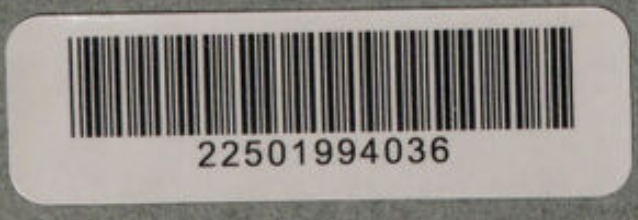

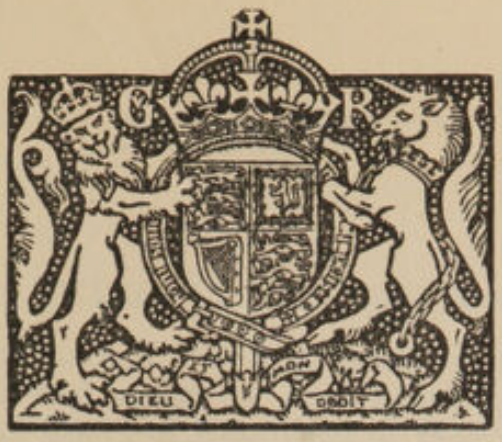

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INTRODUCTORY NOTE.

(1) This Memorandum was first issued in 1909. A revised edition was published under the joint auspices of the Ministry of Health and the Board of Education in 1925. Advantage has been taken of the need for a reprint to make the alterations in the Memorandum necessitated by the issue in 1926 of the revised Code of Regulations for Public Elementary Schools, and in January, 1927, of Administrative Memorandum No. 51.

(2) If there is one general principle more than another upon which this Memorandum lays stress, it is that *if, during epidemics of infectious disease, the power to exclude individual children from School be used to the best advantage, it is only in special and quite exceptional circumstances that it will be necessary to close a School in the interests of public health.* This principle was laid down as one of the fundamental ideas underlying the previous edition of this Memorandum, and the experience of the last 15 years has only gone to strengthen it.

In the past, however, it was possible for Local Education Authorities to close Schools during the prevalence of epidemics of infectious disease not purely in the interests of public health, but on financial grounds, in order to prevent loss of grant owing to the lowered attendance of children at such times. Provision is made in Article 23 (*b*) of the Code to ensure that when Authorities close Schools on the advice or with the approval of the School Medical Officer such advice or approval shall only be given on the ground that closure is necessary for medical reasons, the object being to prevent the diminished attendance during a period of epidemic disease being considered in itself an adequate reason for closure of the School. Further, paragraph 15 (ii) of Administrative Memorandum No. 51, quoted on page 6, secures Authorities against financial loss when Schools are kept open with a greatly lowered attendance.

So far as their own administration is concerned, both the Board and the Ministry act on these principles, and they will not accept the closure of Schools for medical reasons unless such closure is in strict compliance with the principles laid down in this Memorandum.

(3) Like earlier editions, the present Memorandum deals primarily with the closure of Public Elementary Schools and the exclusion of individual children from such Schools on account of infectious disease. It should be remembered, however, that the Board of Education's Regulations for Special Services (Grant Regulations, No. 19) provide Local Sanitary and Education

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Authorities with powers for checking the spread of disease in Special Schools and other Institutions recognised under those Regulations similar to those which the Code provides in connexion with ordinary Public Elementary Schools. The provisions of this Memorandum, therefore, may be taken as applying equally to Schools and Institutions recognised under the Special Services Regulations, with such modifications as the special circumstances of such Schools make necessary.

(4) As regards Secondary Schools, no special provision is made in the Board's Regulations for Secondary Schools in connexion with the closure of such Schools or the exclusion of pupils from them, since the problems of infectious disease seldom arise in an acute form in the case of these Schools, and where they do arise it may be anticipated that the Governing Bodies and Head Masters and Mistresses will be fully alive to the importance of the subject.

PART I.

POWERS OF LOCAL SANITARY AND EDUCATION AUTHORITIES IN CONNEXION WITH SCHOOL CLOSURE AND THE EXCLUSION OF INDIVIDUAL CHILDREN.

(5) The primary responsibility for checking the spread of infectious diseases rests, under the Public Health Acts, with the Local Sanitary Authorities acting through or on the advice of their respective Medical Officers of Health. In order to facilitate their work in so far as it concerns infectious diseases among school children, the Board of Education have made provision in their various Regulations to enable the Local Sanitary Authority or, on certain conditions, two members of that Authority, to secure the closure of Schools or the exclusion of certain children from them. As however the prevention of the spread of infectious disease among school children is also a matter of concern to Local Education Authorities, the Board have further provided in their Regulations for the closure of Schools and exclusion of children by those Authorities acting on the advice or with the approval of their School Medical Officer.

(6) Thus both the Sanitary Authority and the Education Authority will be found to have powers which enable them either to close whole Schools or Departments of Schools or to exclude individual children. The machinery however by which these two different Authorities can put their respective powers into practical use is not identical, and it will be convenient in the first place to set out clearly the means by which each Authority can use its powers. Subsequently suggestions will be made as to the means by which these powers can best be co-ordinated for the purposes of prompt and smooth administration.

(7) *School Closure by the Sanitary Authority.*—Article 22 of the Code of Regulations for Public Elementary Schools, 1926, reads as follows :—" If the Sanitary Authority of the district in which a School is situated, or any two members thereof acting on the advice of the Medical Officer of Health, require either the closure of the School or the exclusion of certain children for a specified time, with a view to preventing the spread of disease or any danger to health likely to arise from the condition of the School, the requirement must at once be complied with."

(8) *School Closure by the Education Authority.*—Article 23 of the Code runs as follows :—

> " A School must make not less than four hundred meetings in each school year subject to :—
>
> . . . . . .
>
> (*b*) an allowance of any meetings missed through closure under the advice or with the approval of the School Medical Officer given on the ground that closure is necessary for

medical reasons, or through closure under the last foregoing Article [Article 22] . . . . . .

Paragraph 15 of Administrative Memorandum No. 51 reads as follows :—

" The attendance registers must be marked every time the department meets, however small the attendance, and the meeting and attendances must be counted in ascertaining the average attendance subject to the following exceptions :—

. . . . . .

(ii) When the attendance of a department has fallen for any week below 60 per cent. of the number of children on the registers, and the Local Education Authority are satisfied by a certificate from the School Medical Officer that the fall may reasonably be attributed to the prevalence of epidemic illness, the meetings and attendances for that week may, in calculating average attendance, be omitted as not being recognized under the Code."

Meetings omitted under the above exception will be treated as missed from " unavoidable causes " for the purposes of Article 23 (*b*) of the Code.

(9) *Exclusion of individual children by the Sanitary Authority.*—This is provided for by Article 22 quoted above.

(10) *Exclusion of individual children by the Education Authority.*—Article 20 (*b*) of the Code reads as follows :—

" The Authority may make arrangements for the ascertainment and exclusion from School of children whose exclusion is desirable either in order to prevent the spread of disease, or on the ground that their uncleanly or verminous condition is detrimental to the other children."

(11) The general effect of the above provisions is as follows :—

(*a*) Schools or Departments may be closed or individual scholars excluded by the Sanitary Authority, or by any two members thereof acting on the advice of the Medical Officer of Health.

(*b*) Schools or Departments may be closed for medical reasons by the Local Education Authority acting on their own initiative, i.e., without orders from the Sanitary Authority ; but Article 23 (b) of the Code will not be satisfied unless the closure is advised or approved by the School Medical Officer on the ground that closure is necessary for medical reasons.

(*c*) Individual children may be excluded from School by the School Medical Officer under arrangements made by the Local Education Authority for that purpose.

The manner in which these powers can be most effectively used will be discussed in Part II of this Memorandum.

PART II.

CO-ORDINATION OF THE POWERS OF LOCAL SANITARY AND EDUCATION AUTHORITIES.

(12) It is unnecessary to point out that though powers for the closure of Schools and the exclusion of individual children from School are possessed both by Sanitary and by Education Authorities, it is only by mutual co-operation that these powers can be used in the best interests of each district. It is the desire alike of the Ministry of Health and of the Board of Education that the relations of the Local Sanitary Authority and the Local Education Authority should in all respects be intimate and cordial in order that the administrative procedures of both bodies may be reciprocally beneficial. The two Departments are at one in making the following suggestions for the most prompt and effective use of the various powers that exist for preventing the spread of infectious disease amongst school children.

(13) It has been the consistent policy both of the Ministry and of the Board ever since the School Medical Service was initiated to urge that whenever possible the Medical Officer of Health should also be the School Medical Officer. This policy has commended itself to the large majority of Local Authorities and in no department of public health is this amalgamation of offices more useful than in that which is concerned with the control of infectious disease.

(14) The areas in which the Sanitary and Educational Authorities are the same are the County Boroughs, and those Municipal Boroughs and Urban Districts of which the Councils are Education Authorities. In all these areas the Sanitary Authority and the Education Authority may appoint the same officer as Medical Officer of Health and School Medical Officer and thus place in the same hands all the medical powers that are enumerated in Part I of this Memorandum. In such areas the only point to be considered is which of these powers is easiest and quickest to put into operation.

(15) Generally speaking it may be said that a joint health officer in one of these areas will find it more convenient to use his powers as School Medical Officer when dealing with the closure of Schools or the exclusion of individual children from School. The reason for this is simple. If he wishes to act as Medical Officer of Health he can only do so by obtaining an order in each case from the Sanitary Authority or two members thereof, and in most cases this involves trouble and delay which can be avoided if he acts in his capacity as School Medical Officer. For Article 20 (b) of the Code makes it possible for the School

Medical Officer to authorise the exclusion of children from School under arrangements made by the Authority for that purpose. If, as School Medical Officer, he wishes to close a School, he can only advise the Education Authority to take the necessary action and cannot act without reference to them, but closure of a School should be a rare and exceptional occurrence for the reasons explained later in this Memorandum. The most frequent need for action is in connexion with the exclusion of individual children and so far as such exclusion goes the joint health officer, acting as School Medical Officer, can act promptly on his own initiative, a matter of great advantage.

(16) In areas in which it is possible to have a joint health officer, but in which, for one reason or another, separate persons hold the appointments of Medical Officer of Health and School Medical Officer, it will remain true that as a general rule the most expeditious action as regards the exclusion of individual children from School can be taken by the School Medical Officer. Moreover, the School Medical Officer is in the nature of things in close and continuous contact with the Schools and it would be as unreasonable as it would be unwise for the Medical Officer of Health and the Sanitary Authority to intervene in the Schools without consulting the School Medical Officer and endeavouring to obtain his concurrence and co-operation. On the other hand, the Medical Officer of Health acting under the Sanitary Authority is responsible for dealing with outbreaks of infectious disease, including such outbreaks in Schools, and this responsibility is in no way diminished by the powers possessed by the Local Education Authority and the School Medical Officer. The importance of this consideration is indicated by the fact that statutory powers as to the prevention and control of infectious disease, the isolation of patients, and the cleansing and disinfection of houses, are possessed by Sanitary Authorities alone.

(17) In these circumstances it is clear that definite working arrangements must be established between the two Authorities and their Officers. The exact details of these arrangements will no doubt vary according to local organisation, but as a general rule the following arrangement will be found to be applicable :—

(*a*) As regards *closure* of Schools, while the ultimate power to enforce such closure is properly secured to the Sanitary Authority, it may be taken for granted that only in the most exceptional circumstances would such power be used without the concurrence of the Local Education Authority and the School Medical Officer. Moreover, if such concurrence is obtained, it will usually be found desirable for the actual order for closure to be issued by the Education Authority on the advice of the School Medical Officer.

(*b*) As regards the *exclusion* of individual children somewhat different considerations arise. It must be borne in mind that the

earliest information as to the occurrence of notifiable diseases may be received by the Medical Officer of Health, who must be in a position to act promptly on this information ; and, in order that he may do so, Local Education Authorities should authorise managers and teachers to carry out any instructions issued by him relative to the exclusion of individual children. The School Medical Officer would be notified by the Medical Officer of Health of any action taken by him and would give any necessary certificate. Where such working arrangements are adopted it should seldom be necessary for the Medical Officer of Health to resort to the cumbersome and slower procedure provided for by Article 22.

(18) There remain for consideration the conditions which obtain in areas where the areas of the Sanitary and the Education Authorities are not coterminous. Normally in County areas, the County Medical Officer of Health is also the County School Medical Officer. But the Executive Sanitary Authorities are the Councils of the Urban and Rural Districts within the County, each acting on the advice of its own District Medical Officer of Health. Where these Medical Officers of Health are also Assistant School Medical Officers they will naturally act in this latter capacity in regard to exclusions of children from School, and usually in regard to closure of Schools also, the County School Medical Officer being prepared to countersign their certificates for such purposes. Where however the District Medical Officer of Health holds no office under the Local Education Authority, the County Education Authority and the Local Sanitary Authority should organise a scheme of co-operation, similar to that suggested in paragraphs (16) and (17) above, the only essential difference being that in this case the Education Authority and the Sanitary Authority concerned will not be subject to the integrating influence of a common Council. This fact however only emphasises the need for friendly working arrangements. It should be the universal rule that a District Medical Officer of Health should never advise closure of a School without the concurrence of the School Medical Officer concerned, save in a really serious emergency. As regards the exclusion of individual children he would act in close co-operation with the County School Medical Officer or his representative in the district in the way described above.

(19) In any case in which the Sanitary Authority require the closure of a Public Elementary School, the notice should be addressed in writing to the Correspondent of the Managers, and should state the grounds on which the closure is deemed necessary. It should be signed either by an authorised Officer of the Sanitary Authority in pursuance of their resolution, or by two members of the Sanitary Authority. In the latter case the notice should make it plain that the two members are acting on the advice of the Medical Officer of Health, who should himself be guided, in determining the need for closure, by the principles

laid down in paragraphs (43) to (47) of this Memorandum. A copy of the notice should be sent to the School Medical Officer.

(20) All such notices must specify a definite time during which the School is to remain closed; this should be as short a period as can be regarded as sufficing on public health grounds, since a second notice may be given before the expiration of the first if it should be found necessary to postpone the re-opening of the School.

(21) Medical Officers of Health are required by Article 14 (4) of the Sanitary Officers Order, 1922, to report to the Minister of Health any serious outbreak of disease. They should include in such reports action, if any, taken in regard to School closure.

(22) Where the School Medical Officer under arrangements made by the Education Authority excludes individual children from a School on the ground that their exclusion is desirable to prevent the spread of disease, he should, where the case so requires, notify the Medical Officer of Health. The Certificate must be produced if required to any Inspector or Officer of the Board of Education's Medical Branch. Should the School Medical Officer advise or approve the closure of a School, he should furnish to the Education Authority a statement in writing showing the grounds on which he advocates the closure of the School in preference to the exclusion of individual scholars, and copies of such written statements should be available for the information of the Board of Education when required.

PART III.

THE COLLECTION OF INFORMATION ABOUT INFECTIOUS DISEASES AMONG CHILDREN.

(23) Success in the control of infection depends on the early recognition of each case of infectious disease, and on the promptitude of the action taken on this information.

(24) As regards notifiable diseases, all known cases of the diseases which come within the scope of the Infectious Disease (Notification) Acts, or of Section 55 of the Public Health (London) Act, or of Regulations under Section 130 of the Public Health Act, 1875, are notified to the Medical Officer of Health.

In non-notifiable infectious diseases, compulsory powers for ensuring early notice of the occurrence of such diseases exist only in particular districts. Measles, whooping-cough, mumps, chicken pox, and infectious diseases other than scarlet fever and diphtheria, which prevail among school children, may be brought within the scope of the Notification Acts by order of the Sanitary Authority made in pursuance of statutory requirements and approved by the Minister of Health or may be made notifiable by Regulations issued by the Minister under Section 130 of the Public Health Act, 1875 (this procedure being rarely adopted in the case of whooping-cough and mumps). Even in districts in which any of these diseases is notifiable the parents commonly either do not consult a doctor or they call him in after secondary infection of other children has already occurred. Additional means therefore have to be devised for securing the early discovery of these cases, and in practice such discovery will be found to depend mainly on the medical organisation of the Local Education Authority, who are in a position to systematise the information which can be secured from teachers, parents, school nurses, and attendance officers. It is essential that each Local Education Authority should make regulations for ascertaining cases in which the exclusion of children from School appears desirable and for conveying the information promptly to the right quarter.

(25) The share of the *teachers* in this work is of primary importance. Infection is often spread in School by the attendance of children suffering from initial and unnoticed symptoms, or during the convalescent stage, or throughout the course of a mild unrecognised attack, of an infectious disease. To minimise the danger, the teachers should be instructed in the symptoms of onset of the chief infectious diseases, and the symptoms which may be manifested by children who have recently passed through the acute stages of these diseases. Clear directions should be given by Local Education Authorities instructing teachers temporarily to exclude children showing any symptom suggestive of any of

these diseases, until medical assurance can be had that they may attend School without harm to themselves or danger to other scholars. Instructions of this kind will naturally find a place in the arrangements referred to in Article 20 (b) of the Code. During the prevalence of any particular infectious disease the attention of the teachers may be drawn, by circular letter or otherwise, to the most obvious symptoms indicating the possibility that a scholar is sickening for, or is suffering or recovering from, such disease.

(26) Similarly, opportunity should be taken by circular letters or otherwise to impress upon *parents* their responsibility in preventing the spread of infection in Schools, especially when any one disease threatens to become prevalent. The particular attention of parents should be drawn to the fact that a " bad cold " or an " ulcerated throat " or a " spring rash " may in fact indicate a mild attack of diphtheria or scarlet fever, and that to send children to School either so suffering or when convalescing from such conditions, without having first obtained a medical opinion, may involve serious consequences to other children.

(27) But by far the most efficient means of procuring information as to the incidence of infectious diseases is the employment of well-trained *nurses*. Their duties for this purpose are twofold: (*a*) to pay frequent visits to Schools, especially during an outbreak of infectious disease, in order to discover children suffering from the disease in its initial stage or in a mild form, and (*b*) to visit the homes of children absent from School, where the alleged reason suggests the possibility of infectious disease, but where no medical certificate is forthcoming. The nurse will of course report to the School Medical Officer, who, if any question of diagnosis arises, will take such action as he considers necessary.

It is needless to say that home visits for this purpose provide an excellent opportunity for giving advice to the parents as to the care of the patient and the avoidance of infection.

(28) Another source of information is provided by the medical inspection schedules of school children, which should contain records of the medical history in respect of infectious disease. These records should be brought up to date at each successive inspection, and the knowledge thus secured can be utilised in determining whether in particular cases children need to be excluded from School, or whether classes need to be closed when an outbreak of infectious disease occurs. This is especially the case in dealing with outbreaks of measles.

(29) Lastly, the services of *school attendance officers* and *health visitors*, in their routine peregrinations, will prove another fruitful source of information.

(30) It should be added that in addition to the notification of ascertained cases of infectious disease, intimation should also

be supplied of the absence from School of any child on the suspicion that it is suffering from an infectious disease, and the absence of several children of one family from School at the same time, no matter what name may be given to the complaint that keeps them at home, should also be reported. In practice it has been found that such intimations of absentees have materially aided the measures taken for the suppression of infectious disease.

(31) It remains to be considered to whom the intimations of infectious or suspicious cases should be sent and what use should be made of them.

In areas where there is a joint health officer who is both Medical Officer of Health and School Medical Officer the procedure is simple. All intimations of infection should be sent to him and he will act upon them on the lines indicated in paragraph (15) above. Where the Medical Officer of Health is not also School Medical Officer, all notifications of notifiable diseases will go in the first instance to the Medical Officer of Health and the information should be promptly transmitted by him to the School Medical Officer and to the Head Teacher of the School concerned in order that the necessary instructions as to exclusion from School, etc., may be given. In the Metropolis, under Section 55 (4) of the Public Health (London) Act, 1891, it is obligatory for the Medical Officer of Health to send a copy of each notification certificate within twelve hours after its receipt to the Head Teacher of the School attended by the patient or by any child who is an inmate of the same house as the patient. In Sanitary Districts outside the Metropolis similar intimations should be sent promptly both to the School Medical Officer and to the Head Teacher. The notice thus sent to the teacher may also usefully comprise printed information on the symptoms of infectious diseases.

(32) In the case of non-notifiable diseases in areas where the Medical Officer of Health is not the School Medical Officer, the system of intimation should be so arranged as to secure the simultaneous conveyance of information to both officers, and it will be for them to make local arrangements for the subsequent measures to be taken. Either the Medical Officer of Health will give the necessary instructions to managers and teachers as to the exclusion of children from School informing the School Medical Officer of the action taken in the manner described in paragraphs (17) (b) and (18) above, or arrangements can be made for the School Medical Officer to give the necessary instructions himself. This is a matter for local arrangement as best suits the circumstances of the locality. The only essential is a clear understanding between the Authorities and Medical Officers concerned as to the part which each is to play in the organisation.

(33) It is important that the health officer concerned should not confine his attention to cases of infection or suspected infection

actually reported to him. He should regard each case of notified disease as possibly connected with other cases of the same disease, which, owing to their mildness, or the absence of some of the characteristic symptoms, have been overlooked by the parent, or the teacher, or both. The investigation of such " missed " cases is indispensable to effective administration. A portion of this investigation may need to be undertaken at the patient's home ; it is incomplete unless an equally thorough inquiry has been made into the condition of the children who have been in contact at School with the scholar who has fallen ill. This inquiry should be shared by the Medical Officer of Health and the School Medical Officer, if these offices are not held by the same official. It should include the recent history and present condition of children who have recently returned to School after an interval of absence, and should be followed by careful watching of the children who have been in contact with the infectious case.

(34) The difficulty occasionally arises that the parents of a child who is suspected to be suffering from a mild attack of an infectious disease cannot afford to send, or will not send, for a doctor, although they have kept the child away from School for a few days. Exclusion from School must be continued in these, as in all, cases of suspicion, until doubt as to the nature of the case has been removed ; and meanwhile the parent must be pressed to utilise the private or public agencies available for medical diagnosis according to circumstances.

PART IV.

GENERAL CONSIDERATIONS AS TO THE ACTION TO BE TAKEN IN RESPECT OF INFECTIOUS DISEASES OCCURRING AMONG SCHOOL CHILDREN.

(35) There is little doubt that infection in Schools is spread to a much greater extent by infectious persons than by infected things, and that by systematically obtaining the information as to the infectious cases indicated in paragraphs (23) to (34), and by adopting the measures of exclusion of patients and of recent " contacts " with them which are described in paragraphs (48) to (74), the common sources of infection can be controlled.

(36) Subject to this chief consideration, certain other administrative lines of action may be here indicated. Disinfection of special class rooms or of particular articles should be undertaken when there is reason to believe that these have been infected. A special caution may be given as to the risk arising from the practice of spitting on slates or from the use in common of penholders and pencils which are apt to be put in the mouth. Steps should be taken to avoid these practices.

(37) The frequent and thorough washing of class rooms and cloak rooms is an efficient means of removing both dust and infection. Dry sweeping on the other hand tends to scatter dust.

(38) Much can be done to prevent the spread of infection by due attention to the sanitation and ventilation of school rooms and cloak rooms, and, so far as practicable, by preventing children having to sit in School in wet clothes or with wet feet. Overcrowding greatly favours the spread of infection, while adequate means of ventilation kept in constant effective use diminish it. It is well established that infection is much reduced in Schools conducted on open-air lines. The water supply of the School should be adequate in quantity and pure in quality ; and lavatories and closets should be kept in a satisfactory state.

(i) *Exclusion of Individual Children.*

(39) It may be laid down as a general principle that all children suffering from any dangerous infectious disease (i.e., of a nature dangerous to some of the persons attacked by it, however mild in other cases) should be excluded from School until there is reason to believe that they have ceased to be in an infectious condition (see Section 126 of the Public Health Act, 1875, and Section 57 of the Public Health Acts Amendment Act, 1907; the latter section may be put in force in any district by Order of the Minister of Health).

Furthermore, as it is seldom possible to provide effectual separation of the sick from the healthy within the homes of children attending Public Elementary Schools, it is often necessary that all

children of an infected household should be excluded from School ; first, because otherwise such children, if unprotected by a previous attack, might attend School while suffering from the disease in a latent form, or at an unrecognised stage ; and secondly, because it is known that the infection of certain diseases may attach itself to, and be conveyed by, the throat secretions or the clothes of a person living in an affected dwelling, even though the person himself remain unaffected. The same considerations will sometimes make it desirable to prohibit the attendance at School of children who are known to have been in contact with a source of infection ; of children of certain ages or classes ; or of children from a particular street or hamlet.

(40) The mode of procedure as regards recognised disease will depend on the natural history of the disease concerned. Patients themselves must not be allowed to attend School (*a*) until free from infection, and (*b*) until such disinfection of the house and of the patient's apparel as may be necessary has been secured. It is impossible to state exactly when personal infection ceases, and the Medical Officer of Health must not assume that, at the and of the ordinary period of isolation, danger to others has without doubt, entirely ceased. It has ceased in the majority of instances ; but in a minority of cases—for instance of scarlet fever and of diphtheria, whether treated at home or in an isolation hospital—the child may remain infectious, often intermittently, for a much more protracted period ; and in practical administration this possibility must be borne in mind and allowed for.

(41) The action with regard to healthy children in the same household as the patient will vary in different instances. The usual procedure is to allow their return to School when an interval a little longer than the maximum known period of incubation of the disease in question has elapsed after the removal to hospital or complete recovery of the patient and the disinfection of the house. In view of the occurrence of slight overlooked cases and of " carrier " cases of infection, it is often advisable to prolong to a certain extent, as indicated hereafter, this period of exclusion from school.

(42) Exclusion from School of the children of infected households most often fails as a means of preventing spread of infection when undiscovered or unrecognised cases or carriers of infection remain in the School. Its failure points to the continued attendance at School of children who have recently had attacks of the prevalent disease in a mild or unrecognised form or who, without themselves being ill, are carriers of infection. Such unrecognised cases are to be sought especially among (*a*) children attending School from the same street or vicinity as the recognised patients ; (*b*) children in the same class ; and especially (*c*) children who on reference to the school register are found to have returned to School after a short absence.

(ii) *School Closure.**

(43) It may be safely laid down as a general principle that *if the power to exclude individual children be used to the best advantage, it is only in special and quite exceptional cases that it will be necessary to close a School in the interests of public health.* School closure may generally be regarded as an indication either of failure to make proper use of the more discriminating and scientific method of excluding individual children, or of inadequate co-operation between the Public Health and the School Authorities. It interferes seriously and unjustifiably with the education of the scholars, and it deprives the Medical Officer of Health and the School Medical Officer of information respecting attacks in their early stage or illness of a doubtful nature which would be obtainable if the Schools were kept open.

(44) As instances of exceptional conditions that may justify the closure of Schools may be mentioned the following: (*a*) infectious sickness in the teacher's family involving risk to the scholars; (*b*) disinfection and cleansing after children suffering from infectious disease have been in attendance (though disinfection should as a rule be completed during a night or week-end); disinfection of articles of equipment need not require the closure of the School though it may temporarily disturb the time-table; (*c*) the rectification of sanitary defects of a nature likely to contribute to outbreaks of disease. In rural areas with a scattered population the closure of isolated Schools with a very small attendance may occasionally aid in preventing the spread of diseases owing to the fact that the children of different households have fewer opportunities for intercourse elsewhere than at School.

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* Sanitary Authorities have no general power in respect of Sunday Schools, or other private Schools, except in so far as these may contravene Section 91 (5), or other provisions of the Public Health Act, 1875; but it will often be expedient to invite the co-operation of Managers of such Schools in efforts for securing the public health. Experience shows that they are usually ready to defer to the representations of the Authority responsible for the public health of the district.

If, however, the Minister of Health, on the application of the Local Authority, has declared Sections 57 and 58 of the Public Health Acts Amendment Act, 1907, to be in force in the district, the Medical Officer of Health will have power to require a child who is or has been suffering from infectious disease or has been exposed to infection to be excluded from School until the Medical Officer has certified that the child may attend School without undue risk of communicating such disease to others (Section 57). The power given to the Sanitary Authority by Section 58 to obtain a complete list of the names and addresses of day scholars in Schools in which any scholar is suffering from infectious disease may be useful to the Medical Officer of Health in his investigation of the causes of outbreaks if he finds it necessary to extend his inquiry to private Schools.

Moreover, in such scattered districts means of tracing doubtful cases and excluding them individually from School are less effective than in more populous areas.

(45) The general position therefore may be summed up as follows. While the power to close a School in the interests of public health must continue to rest both with the Sanitary Authority and with the Local Education Authority acting on the advice of their expert officers, it is a power which should be used with scrupulous care and caution. As a general rule and apart from exceptional circumstances of the nature of those quoted in paragraph (44), closure of a School is not justified unless all the following conditions are simultaneously present, namely unless (*a*) evidence points to the continued meeting of children in School as a source of infection (*b*) cases of infectious disease continue to occur after every effort has been made to discover the infecting cause and (*c*) there is good reason to expect that closure will considerably reduce the likelihood of exposure to infection.

(46) It follows that when a School is closed for any of the above reasons, it is unnecessary to close neighbouring Schools unless they exhibit the same symptoms, though precautions will of course be taken to prevent infectious children from the closed School attending other Schools that remain open. Closure of a School need not necessarily involve the disuse of the School premises (*e.g.*, for evening classes) within the discretion of the Authority.

Where school closure is contemplated, it need not always extend to the whole School or Department. It may on suitable occasions be limited to particular classes.* In fact the closure of a single class by means of the exclusion of each individual child in it will often be found sufficient and preferable to excluding, by closing a department, a number of children whose education need not, on grounds of health, be interrupted.

Playgrounds should not remain open when Schools are closed, as they provide a meeting-place for the children whom it is the object of the closure to keep apart.

(47) School attendance may be greatly lowered during the prevalence of an infectious disease, especially of measles or whooping-cough. But in such circumstances a large proportion of susceptible children have generally already contracted the disease or been exposed to infection, and school closure does little

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* It is to be understood that the exclusion of all the children in a particular class in a Department or School leaving the other children in the Department or School free to attend School is not for the purposes of Article 23 (b) of the Code " closure " of the Department or School, and that the provisions of that Article do not apply in such cases.

to prevent further spread of the disease. As explained in paragraph (8), Administrative Memorandum No. 51 provides that if the attendance of a School sinks below a certain percentage of the number on the books owing to the prevalence of epidemic disease in the district, and if the School remains open, the meetings and attendances may in calculating average attendance be omitted. It will thus be possible to continue the education of the children actually remaining without undue financial loss to the Authority.

PART V.

RULES FOR ACTION IN RESPECT OF PARTICULAR DISEASES.

(48) The diseases for the prevention of which the exclusion of particular children from School or school closure may be required are principally those which spread by infection directly from person to person, such as measles, whooping cough, scarlet fever, diphtheria, epidemic influenza, small pox, chicken pox, and rubella (German measles). In rare cases the same measures may be necessary for enteric fever and diarrhœal diseases, when these spread through the agency of local conditions, such as infected school privies.

(49) In the light of the general principles already set out, the following procedure is suggested in order to enable the Medical Officer of Health or the School Medical Officer to advise as to the minimum duration of exclusion of school children which can with reasonable safety be adopted in the several more common infectious diseases. It should be noted that although certain recommendations are made as to duration of exclusion of patients and of " contacts " with them, these recommendations are subject to the proviso that *each case as it occurs requires and should receive individual consideration.*

SCARLET FEVER.

A. Rules for Exclusion of Individuals.

(1) *As regards each child attacked by the disease.*

(50) (*a*) *When treated in the Isolation Hospital* he is usually detained for about six weeks, and longer if any discharges continue from ear, nose, or throat. After return home, in view of the occasional protracted infectiousness of patients with such discharges, and sometimes even of those without them, the child should not return to School for two weeks and a notice should be sent to the teacher and another to the parent to this effect. Wherever practicable, however, the child should be examined by the School Medical Officer or by an experienced Health Visitor or School Nurse before re-admission to School, and where this practice is followed it may be permissible for a child, free from any sign of infection, to return at the expiry of one week.†

† A longer period, e.g., of four weeks may not infrequently be necessary, not only in view of the health of the patient, but also if the occurrence of mucous discharges or other circumstances indicate that some measure of infectiousness may persist after cessation of home or hospital isolation.

(*b*) *When the patient has been treated at home* similar rules apply, provided that the patient and his rooms have been effectively disinfected after the illness has ended.

(2) *As regards children living in infected houses.*

(51) (*a*) If the patient has been removed to the Isolation Hospital the teacher and the parents should be instructed to keep children living in the same house away from School for a period of one week from the day on which disinfection, subsequent to the removal of the patient, has taken place, and the parents should be instructed to keep these children out of contact with other children for the same period. An exception to this rule may be made for those children in respect of whom the School Medical Officer has satisfied himself, directly or through the Medical Officer of Health, that they have already had the disease ; such children may be allowed to return to School immediately after disinfection of the premises.

(*b*) If the patient is treated at home no other children from the same house should attend School while the patient is infectious, nor for one week after the end of his period of isolation.

(3) *As regards Teachers, Caretakers, etc.*

(52) The same rules apply as for children.

B. Rules for Closure of School for Scarlet Fever.

(53) If there is active co-operation between the school attendance officers and teachers and the Medical Officer of Health, school closure should only exceptionally be needed for scarlet fever. In School this disease usually spreads slowly from child to child, and not in the explosive manner characteristic of measles. Hence diligent search for slight cases and supervision of " contacts " should in most instances render school closure needless.

DIPHTHERIA.

A. Clinical and Bacteriological Examinations.

(54) The first step to be taken on the occurrence of a case of diphtheria must be a careful search among all class or School " contacts " for other children showing clinical signs of the disease, who should, of course, be excluded.

Search should also be pursued for children suffering from sore throat, sore nose (especially if the soreness is one-sided and associated with irritating discharge), aural discharge, enlarged

glands or unusual pallor, and such children should be temporarily excluded if this is considered necessary, bacteriological methods being used subsequently to assist in determining the nature of the condition.

Swabs should be taken, whenever practicable, of all children in the same class who have been sitting in proximity to the patient, as well as of those referred to above. In exceptional cases it may be advisable to extend the procedure to all children and teachers in a class, or even throughout a Department or School. Swabs should also be taken of all members of the patient's household.*

B. Rules for Exclusion of Individuals.

(1) *As regards each child attacked by the disease.*

(55) Whether treated in the isolation hospital, or at home, it is the practice in some districts to regard the patient as in an infective condition until three successive swabs taken on different days have given consistent negative results. These swabs should not be taken until at least 48 hours have elapsed since the last application of any disinfectant to the throat.

In certain hospitals it is now the practice to rely upon the complete recovery of a patient from all clinical symptoms of the disease rather than upon bacteriological methods, and the experience of these hospitals seems to show that by such means the spread of infection can usually be avoided.

In view of the debility left by an attack of diphtheria, return to School should usually be deferred for two or three weeks or longer, at the discretion of the Medical Officer, after the end of the attack, as determined by bacteriological or clinical methods.

(2) *As regards Contacts.*

(56) (*a*) Contacts in respect of whom positive swabs have been obtained should, as a general rule, be excluded from School until two or three successive swabs give negative results. If circumstances permit, tests for virulence may be employed, and this should always be done, if possible, in cases where the bacilli persist for long periods without any signs of disease. If the organism has been shown to be non-virulent a child may be dealt with as though the swab were negative.

(*b*) When the patient has been removed to the isolation hospital, the children in the same house should be kept away from School for two weeks. During this period they should be closely watched for any signs of

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* *See* also Memorandum on Diphtheria Antitoxin and Methods of Immunisation for the Prevention of Diphtheria (Ministry of Health).

diphtheria developing, and should only be readmitted after a final careful clinical examination, which should be supplemented by the taking of a swab, with negative result. In the case of a child free from any signs of disease, the period of two weeks may be shortened at the discretion of the Medical Officer when bacteriological examinations have been made with negative result.

(*c*) When the patient is treated at home, no other child from the same house should attend School while the patient is infectious, nor for ten days afterwards. This period must be extended in the case of children suffering from sore throat, sore nose, or any other signs of possible infectivity until a bacteriological report establishes their non-diphtherial nature. In exceptional cases, where complete isolation can be procured, contacts may be dealt with as though the patient had been removed to hospital.

C. Rules for School Closure for Diphtheria.

(57) Although diphtheria, like scarlet fever, and unlike measles, usually spreads comparatively slowly in Schools, it is apt to be very persistent, and not infrequently causes serious mortality especially among children under five years old. For these reasons, when cases of this disease occur in an Infant School, there should be no hesitation in excluding children from attendance who are below the age of compulsory school attendance. Closure of a School or Department is only justifiable when the precautionary measures detailed in the preceding paragraphs have failed to arrest the spread of the disease.

The need for protracted exclusion from School of recent diphtheria patients has already been emphasised. The systematic use of these measures should obviate the need for School closure for diphtheria.

ENTERIC FEVER AND ERYSIPELAS.

(58) Children coming from houses in which have occurred cases of erysipelas or of enteric (typhoid) fever who are not themselves ill, need not as a rule be excluded from School. Nor is School closure required for either of these diseases, except in the rare instances in which enteric fever is due to some condition directly connected with the School.

MEASLES.

A. Characteristics of the Disease.

(59) In towns the attack-rate is highest in the third, fourth, and fifth years of life, while the death-rate caused by the disease is highest in the second year of life. After the age of five the death-

rate caused by it is relatively very small. These facts clearly indicate the importance of postponing an attack of measles, and of adopting special measures to ensure increased safety for children under five.*

Persons seldom contract measles a second time, and as in populous districts epidemics commonly recur every two or three years, most of the older children are protected against it by having passed through a previous attack. But this consideration may not apply to a country village, in which epidemics may be absent for a long series of years.

The early infectiousness of measles while the symptoms are only those of a common " cold " is another noteworthy feature of this disease. It is not unlikely that a majority of the total cases are infected by patients in this early stage. The incubation period from infection to the commencement of catarrhal symptoms is 12 to 14 days with fair constancy, but may be a few days less.

Although measles is very infectious its infection does not appear to be long-lived, nor to be commonly conveyed by healthy persons. It thus differs from small pox, scarlet fever, and diphtheria.

But though there is reasonable ground for the opinion that measles is not readily, if at all, conveyed to School by healthy children coming from infected households, it is desirable, particularly in view of the greater fatality of attacks of measles in children under five years of age, to assume the possibility of such spread by intermediaries in regard to scholars attending the Infant School, and to act accordingly as stated below.

B. Rules for the Exclusion of Individuals.

(1) *As regards children suffering from the disease.*

(60) Children attacked by measles should be kept from School for three weeks from the first appearance of the rash. This period should be extended if there are complications or sequelæ.

(2) *As regards other children living in infected houses.*

(61) In large towns, and in the smaller districts in which the majority of children over seven years of age who are attending Public Elementary Schools have had measles, the practice is frequently adopted, when measles breaks out in a household, of excluding from school attendance only those children of the same household who attend the Infant School, and those older children of the same household who have not had measles. These particular children of the same household should be excluded from School until 21 days from the date of onset of the illness of the last patient with measles in the house.

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* *See* Report on the Prevention of Mortality and Disablement due to Measles and Pneumonia in Children—(Reports to Local Government Board, New Series No. 115, 1918).

(62) The above procedure can be recommended, as the result of experience in large districts, to be worthy of general adoption ; but it may need to be modified in accordance with the special circumstances of a district, particularly with reference to its past history as to measles. In order that the procedure may be efficiently carried out, it is very desirable that the past history of every child in regard to infectious disease, as recorded on the medical inspection card, should be tabulated, and that the table so obtained should be kept up-to-date in each class, and readily available for the purpose of determining, when a case of measles occurs, which children should, and which should not, be excluded from attendance at School.

C. Rules for School Closure for Measles.

(63) Although school closure has been, and is still being adopted more frequently on account of epidemics of measles than for any other disease, there is a general consensus of opinion that except in the case of scattered rural populations, it is useless as a means of checking the spread of the disease. As a rule, closure is deferred until a large proportion of the children are already absent, but even in those cases where early class closure has been attempted after the occurrence of a single case, experience appears to show that the only effect is to postpone and prolong the epidemic. It appears certain that in populous districts school closure for measles has but little value as a public health measure.

In thinly populated districts, where the homes are comparatively isolated, and children have long distances to come to School, school closure may on the other hand have a very definite value, in preventing the spread of measles from one village to another, and in reducing the risk of exposure to bad weather of those children who are already in the early stages of the disease.

D. Other Preventive Measures.

(64) *Warnings to Parents.*—Warning notices to parents have been found to be valuable in preventing the spread of measles through the attendance at School of infecting children. These warnings should be sent out as soon as measles has appeared in a class, the parents being warned to watch their children and to keep them from School if the slightest symptoms of a " cold " develop during the following three weeks.

The warning notice should also suggest that the parent should at once inform the teacher if the symptoms develop. The teacher can then report the case to the Medical Officer of Health and the School Medical Officer.

(65) *Visits by Nurses.* Measles is pre-eminently a disease in which the service of well-trained nurses should be fully utilised. Wherever circumstances permit, a School Nurse or Health Visitor should be instructed to visit every home from which a case of

measles is reported, unless it has been ascertained that a doctor is in attendance. The nurse must, of course, be thoroughly familiar with the symptoms of the disease, and her reports should be available simultaneously to the Health and School Medical Departments (see para. (32) above). This is the most effective available means of checking diagnosis made by a parent or teacher and of determining the need for, and period of, exclusion.

The nurse, when visiting a home, will naturally take the opportunity of advising parents as to the care of children suffering from this disease, and as to the avoidance of the spread of infection both within and without the home.

GERMAN MEASLES.

(66) In this mild disease (Rubella, Rõteln) children need not be excluded from school for more than a week, dating from the first appearance of the rash. Immediate child-contacts in the home who have not had German measles should be excluded from school for three weeks from date of last exposure to infection by a patient in the eruptive stage.

WHOOPING COUGH.

(67) The rules as to exclusion from or closure of School for this disease should be similar to those for measles, except that the infection of whooping cough probably lasts six weeks, and the children in the house who attend the Infant School should therefore be excluded from School for this period—or as long as the cough continues.

SMALL POX.

(68) Children suffering from small pox should be excluded until all scabs and "seeds" have disappeared. All contacts should be vaccinated or revaccinated, and should be kept under medical observation for a period of 16 days: for this purpose exclusion of contacts from school is not generally necessary or desirable.*

CHICKEN POX.

(69) Children suffering from this disease should be excluded for three weeks or until all scabs have disappeared. The possibility of small pox should always be kept in mind, and inquiry should be made in all instances as to the state of vaccination of supposed cases of chicken pox. Infants, and other children who have not had chicken pox, should be excluded from School for three weeks from the date of the last exposure to infection.

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* *See* Memorandum on the steps requisite to be taken by Sanitary Authorities on the occurrence of small pox (Ministry of Health, 71a/Med.).

MUMPS.

(70) Children suffering from mumps should be excluded and not readmitted until one week after the subsidence of the swelling. In this disease, owing to its character and long incubation period, exclusion may, as a rule, be confined to the patient himself.

INFLUENZA.

(71) Children showing symptoms of influenza should be excluded from School during the period of attack, and should not be readmitted until a careful medical examination of the heart and lungs has been made to eliminate possible latent complications and sequelæ.*

In epidemics of influenza closure of schools may be employed occasionally with advantage, particularly in rural and small urban districts where the excluded children have few opportunities of coming in contact with each other outside the School.

TUBERCULOSIS.

(72) Pulmonary tuberculosis in a recognisable form is seldom a large factor in school life. Children known to be suffering from this disease should, at the discretion of the School Medical Officer, be excluded from School. All cases of open tuberculosis other than pulmonary should of course be excluded.

A teacher found to be suffering from pulmonary tuberculosis is not regarded by the Board as a suitable member of the staff of a Public Elementary School, or of a Secondary, Technical or other school, and if he is recognized by the Board under the Code his continued recognition is conditional on his abstaining from teaching until he can submit two consecutive medical certificates, viz., one stating that the disease is quiescent, and the other, six months later, stating that the improvement in his general and local physical condition has been maintained. If these are satisfactory he is then regarded as fit to resume the duties of a teacher but his continued recognition is subject to reconsideration in the light of subsequent medical certificates, which are required (*a*) six months after the last report, and then (*b*) after a period of one year, (*c*) after a period of another year.

The Board, however, do not object to the employment in a certified Open Air School or a Sanatorium for tuberculous children of a teacher suffering from pulmonary tuberculosis provided either that a medical report has been submitted to the Board stating that the disease has become quiescent, or that the medical Superintendent of the Institution can certify that the employment is not likely to prove injurious to the teacher or to the children in his charge.

Local Education Authorities should take steps to ensure that the general conditions outlined above shall govern the employment of Teachers, Caretakers or other members of the staff of schools in their areas.

EPIDEMIC DISEASES OF THE CENTRAL NERVOUS SYSTEM.

(73) Within the past ten years there has been an increased prevalence of cerebro-spinal fever and acute poliomyelitis in England and Wales, in epidemic as well as in sporadic form.

* *See* Memorandum on the Prevention of Influenza (Ministry of Health).

Since 1918 encephalitis lethargica has also similarly been recognised in this country. Each of these diseases is now notifiable as soon as the diagnosis has been made.

Cerebro-Spinal Fever.

(74) The incubation period is variable ; twenty-four hours to ten days have been assigned as its limits ; the majority of authorities consider the average duration of incubation to be four days. Healthy persons may harbour the meningococcus for seven weeks or longer ; it is exceptional for such persons (who have become carriers through contact with patients) to develop the disease although they may transmit the germ to others, some of whom will be susceptible to infection. A child suffering from cerebro-spinal meningitis will not even in favourable circumstances be in a fit state of health to attend school until three months have elapsed from the onset of the illness.

Immediately the disease is recognised in a school, the class-contacts should be kept under close medical observation for two weeks. If it can be arranged such contacts should be accommodated in open-air classes. Home-contacts should be excluded from school for a period of three weeks.

The disease has a high degree of fatality ; in the event of recovery, sequelæ are not often present. Some patients display mental instability and irritability of temper, and it is desirable that all such cases should be kept under special medical observation for a year.

Acute Poliomyelitis.

(75) The incubation period is usually placed at from two to ten days, the average period being three to four days. A child developing the disease should forthwith be excluded from School. If the paralytic signs are absent or extremely slight and the general health is good, the child may be readmitted to School at the expiration of six weeks. Careful watch should be maintained in non-paralytic cases for the supervention of paralysis, as recurrent cases occur in which the paralysis is manifested after the acute symptoms have subsided. Paralytic cases will require a much longer period of school exclusion and are afterwards better treated, if practicable, in special orthopædic institutions.

In times of epidemic prevalence, exclusion of all children in a particular class, closure of Infant Departments, and even of the whole School, may be required. It is highly important in epidemic periods to recognise mild and abortive cases of poliomyelitis, as they are largely instrumental in spreading the disease. The class-contacts of a child suffering from poliomyelitis should be carefully examined from this point of view, and any such child showing symptoms of gastro-intestinal disorder (vomiting, mild diarrhœa, etc.), catarrh of the upper respiratory passages, or muscular twitchings, neuritic pains, etc., should be regarded

provisionally with suspicion, and should be kept under supervision and, if necessary, excluded from School. Home-contacts should be excluded from School for a minimum period of three weeks.

Encephalitis Lethargica.

(76) In this disease the duration of the incubation period cannot be specified at present. If the disease develops in a School, the child should at once be sent home and care be taken to see that it is receiving suitable medical care in hospital or otherwise.

Search should be made for school-contacts of the case. These contacts should be medically examined and watched. Any child exhibiting signs and symptoms suggestive of a mild or abortive form of encephalitis lethargica should be excluded from School for a minimum period of six weeks.*

Home-contacts in the affected household should be kept from School for three weeks after the isolation of the patient. Children who have suffered from the disease take a long time to recuperate, and they should not be allowed to resume school attendance until a careful medical examination pronounces the general health completely restored. In favourable circumstances a child may be permitted to resume School after the lapse of six months from the time of school exclusion ; in many instances this period has to be extended to a year or even longer.

All children who have suffered from epidemic encephalitis, whether in the abortive, mild or severe forms of the disease, should be kept under careful medical observation for a period of two years after the attack, as sequelæ may appear at any time within this period. Sequelæ may be found : (1) in the course of the original acute malady, and persist after partial or complete disappearance of all other symptoms ; or (2) after the original acute attack has apparently terminated or possibly has passed unrecognised. The more important of these after-effects may include mental symptoms, symptomatic paralysis agitans, excito-motor sequelæ, and various sensory conditions.

As a rule, children showing after-effects, unless in the mildest possible degree, should be excluded altogether from School, partly for their own sake and partly on account of the effect upon other children.

Signed on behalf of the Board of Education and the Minister of Health.

GEORGE NEWMAN, M.D.

WHITEHALL,
July, 1927.

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* *See* Memorandum on Encephalitis Lethargica (Ministry of Health).

APPENDIX.

Incubation and Exclusion Periods of the Commoner Infectious Diseases.

It should be understood, when this table is used, that infectious disease is a process, not an entity, and that the process is liable to modification by many circumstances, such as the intensity of the infection, and the condition and resistant power of the body. As human beings vary in their general and special characteristics, it is probable that in no two persons will the process be precisely similar. The visible signs, by which alone the disease is manifested, are accelerated or retarded, accentuated, diminished or suppressed in accordance with these conditions. The periods indicated in the second and third columns of this table should therefore be regarded as approximate only, and liable to variation.

Disease.	Incubation Period.	Interval between onset of illness and appearance of rash.	Period of Exclusion.	
			Patients.	Contacts.
Scarlet Fever.	1–8 days.	1–2 days.	Two weeks after return from hospital, or, in the case of patients treated at home, two weeks after release from isolation.	One week after removal of patient to hospital, or, in the case of patients at home, one week after release from isolation.
Diphtheria	2–10 days.	—	Two to three weeks after end of attack; or until pronounced free from infection by a medical practitioner.	Two weeks after removal of patient to hospital, or, in the case of patients treated at home, ten days after release from isolation. Negative swabs should be obtained.
Measles . .	7–14 days.	4 days	Three weeks from date of appearance of rash.	Infants, and other children who have not had the disease, three weeks from date of onset of last case in house.
German Measles.	5–21 days.	0–2 days.	One week from date of appearance of rash.	Infants, and other children who have not had the disease, three weeks from date of last exposure to patient with rash.

APPENDIX—*continued.*

Disease.	Incubation Period.	Interval between onset of illness and appearance of rash.	Period of Exclusion.	
			Patient.	Contacts.
Whooping Cough.	6–18 days.	—	Six weeks from commencement of cough.	Infants only, for six weeks from date of onset of last case, or three weeks from date of last exposure to infection.
Mumps ..	12–23 days.	—	Until one week after subsidence of swelling.	No exclusion.
Chicken Pox.	11–21 days.	0–2 days.	Three weeks, or until all scabs have disappeared.	Infants, and other children who have not had the disease, three weeks from date of last exposure to infection.
Small Pox	10–14, but usually 12 days.	3 days	Six weeks, or until the patient is certified free from infection by a medical practitioner.	Sixteen days, unless recently vaccinated, when exclusion is unnecessary.

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