

Measles (rubeola)

Disease Category: Vaccine Preventable Diseases

Timeframe to follow-up: Immediately

Initial Notifications	- Upon receiving initial notification, immediately notify OSE's State Medical Epidemiologist and State Epidemiologist - State Epidemiologist will then notify OSE's VPD Coordinator, DPBH's Immunization program, and DPBH's Community Health program - State Epidemiologist will alert Nevada State Public Health Laboratory of incoming specimens for confirmatory testing.
Signs and Symptoms ⁶	- Prodrome (high fever AND cough OR runny nose OR red watery eyes) 7–14 days after contact - White spots in mouth (Koplik Spots) may appear 2–3 days after onset of initial symptoms - Maculopapular rash 3–5 days after onset of initial symptoms, typically begins on the head (often the hairline) and spreads downward, usually becoming a full body rash.
Incubation ⁷	11–12 days for prodrome symptoms - Usually 14 days for rash onset; range 7–21 days
Case Classification ⁸	Clinical criteria: An acute illness characterized by: - Generalized, maculopapular rash lasting ≥ 3 days; and - Temperature $\geq 101^{\circ}\text{F}$ or 38.3°C; and - Cough, coryza, or conjunctivitis. Confirmed: An acute febrile rash illness† with: - Isolation of measles virus‡ from a clinical specimen; or - Detection of measles-virus specific nucleic acid‡ from a clinical specimen using polymerase chain reaction; or - IgG seroconversion‡ or a significant rise in measles immunoglobulin G antibody‡ using any evaluated and validated method; or - A positive serologic test for measles immunoglobulin M antibody‡§; or - Direct epidemiologic linkage to a case confirmed by one of the methods above. † Temperature does not need to reach $\geq 101^{\circ}\text{F}/38.3^{\circ}\text{C}$ and rash does not need to last ≥ 3 days. ‡ Not explained by MMR vaccination during the previous 6–45 days. § Not otherwise ruled out by other confirmatory testing or more specific measles testing in a public health laboratory. Probable: In the absence of a more likely diagnosis, an illness that meets the clinical description with: - No epidemiologic linkage to a laboratory-confirmed measles case; and - Noncontributory or no measles laboratory testing.
Differential Diagnosis ⁹	Coxsackievirus, Echovirus, Epstein-Barr virus (EBV), Fifth disease (erythema infectiosum) – parvovirus B19, HIV (acute retroviral syndrome), Influenza, Pharyngoconjunctival fever – adenovirus, Roseola infantum – HHV-6/HHV-7, Rubella, Zika virus, Kawasaki disease, Meningitis (bacterial or viral; when caused by Neisseria meningitidis may involve rash), Scarlet fever – Streptococcus pyogenes (Group A strep), Systemic lupus erythematosus (SLE), Toxic shock syndrome (TSS) – Staphylococcus aureus or Streptococcus pyogenes

<u>Treatment</u> ¹⁰	There is no specific antiviral therapy for measles. Supportive care includes symptom relief and management of complications (e.g., pneumonia, otitis media, dehydration). Vitamin A supplementation may be indicated as supportive treatment for children with measles, particularly in hospitalized cases. It can help reduce the risk of serious complications, but it is not a cure, and it does not prevent measles. It should only be administered under the supervision of a healthcare provider.
Duration	Symptoms usually persist for 7–10 days • Prodrome stage: 2 to 4 days • Rash: 5 to 6 days
<u>Exposure</u>	Measles spreads person-to-person via respiratory droplets or airborne transmission. The virus can remain infectious in air for up to 2 hours.
<u>Laboratory Testing</u>	If measles is suspected, healthcare providers should collect the following specimens for testing at Nevada State Public Health Laboratory (NSPHL): RT-PCR: nasopharyngeal or throat swabs should be collected within 72 hours of rash onset. Collection of a urine specimen can improve sensitivity but is not a priority. Serum for IgM and IgG testing: Measles specific IgM antibody may not be present until ≥72 hours after rash onset and can persist for at least 30 days after rash onset. False positive measles IgM results are common. IgG antibody may also show a significant rise between acute and convalescent titers. Laboratories are asked to submit isolates of <i>measles</i> species to NSPHL for confirmation. . Local Health Authorities can facilitate testing if an outbreak is suspected OR for contacts of cases: • Nevada State Public Health Laboratory (NSPHL) can perform culture, PCR and sequencing (WGS) for cluster and outbreak investigations. • Instructions for PCR testing are found here
<u>Control of Contacts</u>	• Identify all contacts and evaluate immunization status and risk of infection. ◦ Refer to providers for PEP if not immunized or under immunized. • Exclude contact as necessary from high-risk settings • Conduct surveillance on contacts for 21 days since last exposure to case to ensure symptoms do not present.
Key areas of focus during investigation	Symptoms and onset, contacts, travel history, vaccination status
Public Health Actions	Reports of measles cases must be made to the Local Health Authority within 24 hours following the identification of the case.

	Local Health Authority to notify Office of State Epidemiology (dpbhepi@health.nv.gov) or call 775-400-0333 for individual cases or if outbreak suspected. For individual confirmed or probable cases: • Coordinate transport of specimens to NSPHL to confirm diagnosis. • Isolate case until 4 days after rash onset or until measles is ruled out. • Identify potential exposures. • Identify any contacts and sites where case spent time while contagious. • Make appropriate recommendations to contacts. • Coordinate with other health agencies (LHA's, CDC) or affected organizations as needed (schools, childcare, events). • Prepare a case report and submit to the Chief Medical Officer (through OSE) within 7 days after completing the case investigation. • Conduct active surveillance for additional cases. • Identify potential outbreaks from common sources. • Provide education about how to prevent transmission. To the best of the local health authority's ability, each step of the investigation should be completed within one working day or in alignment with NAC 441A.
<u>Key Partner Agencies</u>	• Local health authorities • Nevada State Public Health Lab (NSPHL) • Other States involved in outbreaks

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MEASLES (RUBEOLA)

I. DISEASE REPORTING

A. Legal Reporting Requirements

A report to the health authority may be made by telephone; telecopy (in the form prescribed by the health authority); or any form of electronic communication identified by the health authority, following the specified format and procedure.¹

1. *Health Care Providers and Health Care Facilities*

Health providers and facilities must notify the health authority where provider is located immediately after identifying the case.¹⁻³

2. *Laboratories*

Laboratories must notify the health authority immediately after identifying a case.¹ If the lab is located outside of Nevada, notify the Nevada Chief Medical Officer through the Office of State Epidemiology (OSE) within the same timeframe.^{1,4}

3. *Local Health Authority (LHA)*

LHA's must notify the Office of State Epidemiology (OSE) within 7 days after completing the case investigation.⁵

II. THE DISEASE AND ITS EPIDEMIOLOGY

A. Background

Measles is a highly contagious illness caused by a virus. Prior to the availability of the measles vaccine, the disease affected almost every American. After the vaccine became available, endemic measles was declared “eliminated” from the United States, but surges of cases still occur.¹⁵

For the most current information on measles, please visit the CDC [website](#).

B. Etiologic Agent¹⁰

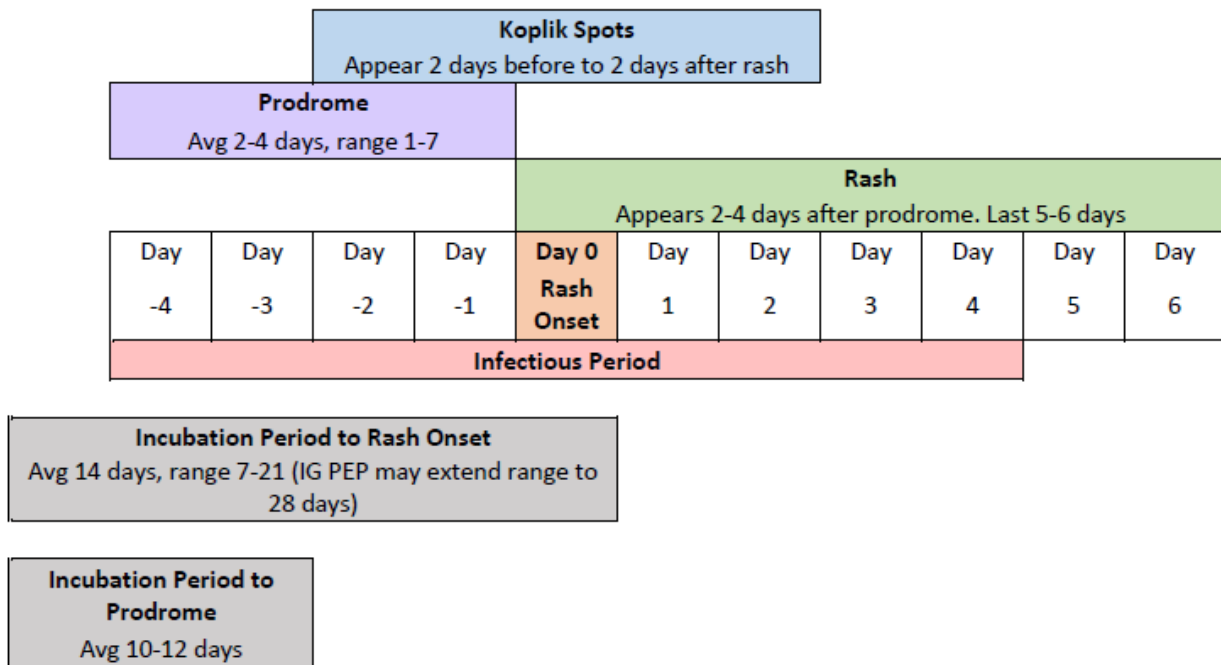
Measles is caused by a single-stranded, enveloped RNA virus with one serotype. It is classified as a member of the genus *Morbillivirus* in the *Paramyxoviridae* family.

C. Description of Illness⁷

Measles is one of the most contagious of all infectious diseases: up to 9 out of 10 susceptible people with close contact with a measles patient will develop measles. It is an acute, highly communicable viral disease that begins with prodromal symptoms, including fever, conjunctivitis, coryza, and cough. These symptoms typically last for 2-4 days before the rash appears. One of the hallmark signs is the presence of Koplik spots—small, white or bluish-white spots on an erythematous base on the buccal mucosa, which are pathognomonic but

can be difficult to detect. On days 3 to 7, a characteristic red maculopapular rash emerges, initially on the face, and then spreads across the body, lasting 4-7 days. The rash typically begins along the hair line and spreads downward reaching the hands and feet.

Timeline: Measles Signs and Symptoms, Incubation Period, and Infectious Period



It is important to note that temperatures may exceed 104°F, usually declining 2-3 days after the rash appears. However, if a high fever persists beyond the third day of the rash, this may indicate complications such as otitis media, pneumonia, or encephalitis.

Infants and children younger than 5 years of age, adults over the age of 20 years, pregnant women, and people with weakened immune systems due to existing morbidities (e.g., cancer or HIV infections) are at higher risk for complications from measles. Complications can include otitis media, bronchopneumonia, laryngotracheobronchitis (croup), and diarrhea.¹⁸ Measles can cause serious illness in young children, including encephalitis resulting in permanent brain damage; 1 in 3 out of every 1,000 children will die from respiratory and neurologic complications; and some develop subacute sclerosing panencephalitis (SSPE) which is a rare, fatal degenerative disease of the central nervous system. Measles infection during pregnancy can lead to adverse outcomes including pneumonia and death for mother, pregnancy loss, premature delivery, and low birth weight. Measles can be transmitted during pregnancy and can result in congenital infection.^{10,18}

D. Disease Burden in Nevada

As of 2026, measles is not considered endemic to Nevada.

See the [Nevada Office of State Epidemiology Communicable Disease Dashboard](#) for Nevada specific data on measles under the “Communicable Disease Dashboard” under Vaccine Preventable Section.

E. Reservoirs⁷

Acutely infected humans.

F. Modes of Transmission¹⁰

Person-to-person by direct contact with infectious droplets or airborne spread. Virus remains viable for up to 2 hours in air or on surfaces but is sensitive to environmental factors such as ultraviolet light and drying.

G. Incubation Period^{7,18}

From exposure to onset of prodromal symptoms, the incubation period averages 11 to 12 days; from exposure to rash onset, incubation averages 14 days with a range of 7-21 days. Immunoglobulin given for passive protection early in the incubation period may extend the incubation period to 28 days

H. Period of Communicability

Measles is most contagious during the onset of prodrome through the first 3-4 days of rash.⁷ The contagious period is defined as 4 days prior to onset of rash and at least 4 days after the date of rash onset.¹⁸

Immuno-compromised individuals should be considered contagious for the duration of illness.¹⁸

I. Testing¹²

If measles is suspected, the healthcare provider should collect either a nasopharyngeal (NP) or throat (OP) swab for RT-PCR testing as well as serum for serology testing for measles specific immunoglobulin M (IgM). Immunoglobulin G (IgG) can also be used to look for significant increases in titer levels during acute and convalescent stages. A urine specimen may be collected to improve testing sensitivity but is not a priority for the investigation. Laboratories are asked to submit isolates of *measles* species to NSPHL for confirmation and further characterization. Collection instructions may be found at NSPHL's [Directory of Services](#).

Blood for serologic testing is typically sent to commercial laboratories. CDC performs serological and RT-PCR testing in support of outbreak investigation. The Nevada State Public Health Lab performs RT-PCR on throat, nasopharyngeal (preferred), or nasal swabs. Synthetic swabs are recommended, and swabs should be transferred in 1-3ml of viral transport medium. Urine specimens in addition to nasopharyngeal or throat swab can help increase sensitivity especially at the end of the RT-PCR detection window.

Contact the Nevada State Public Health Lab for guidance on appropriate sample types and shipping requirements for Measles.¹³

J. Treatment¹⁸

There is no specific antiviral agent for treatment of measles infection. Vitamin A supplementation may be indicated as supportive treatment for children with measles, particularly in hospitalized cases. It can help reduce the risk of serious complications, but it is not a cure, and it does not prevent measles. It should only be administered under the supervision of a healthcare provider. Dosing vitamin A for treatment of children with measles can be found in the Red Book chapter on [measles](#).

Postexposure Prophylaxis (PEP) is given to exposed individuals who are susceptible to measles (e.g., non-immunized, under-immunized, pregnant women) to protect against measles or modify disease course. Please refer to Red Book for the most up to date recommendations for PEP in the form of the MMR vaccine or Immunoglobulin (IG) for exposed individuals. See measles chapter the Red Book for recommended PEP for people exposed to measles who are not pregnant or immunocompromised and people who are pregnant or immunocompromised.

K. Immunization¹¹

The two dose MMR (Measles, Mumps, Rubella) vaccine is 97% effective against measles. Most people who are vaccinated with the MMR or MMRV (Measles, Mumps, Rubella, Varicella) have life-long immunity. The MMR is recommended for children, with the first dose given at 12-15 months and the second dose given at 4-6 years. The MMRV is recommended for children 12 months through 12 years. The first dose is administered 12-15 months and the second is given at 4-6 years.

III. EPIDEMIOLOGIC CASE INVESTIGATION

The public health authority should begin investigating the case of measles, step by step, immediately upon notification in alignment with [NAC 441A](#).

According to NRS 441A.160 (1), "A health authority who knows, suspects or is informed of the existence within the jurisdiction of the health authority of any communicable disease that poses a risk to the health of the public and is in an infectious state, at risk of developing into an infectious state or at risk of developing into a progressed state that endangers the health of the person with the communicable disease shall immediately investigate the matter and all circumstances connected with it, and shall take such measures for the prevention, suppression and control of the disease as are required by the regulations of the Board or a district board of health."¹⁹

A disease investigator from the public health authority will be assigned to investigate the case based on their availability and on the workload distribution among the entire disease investigation team.

A. Step 1: Review relevant information about the disease.

1. Review scientific information in [Control of Communicable Diseases Manual](#), most current edition.
2. Review [Measles case definition](#) (2013 CDC).
3. Review [Chapter 7: Measles in the Manual for the Surveillance of Vaccine-Preventable Diseases](#) (2025 CDC)

B. Step 2: Begin investigating the case.

1. Contact Reporting Source and/or Reported Case

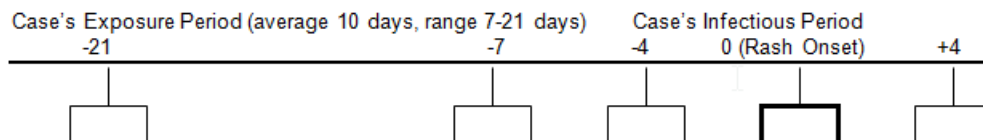
Upon receiving an initial case report, review lab test results and available clinical details and epidemiologic factors. Attempt to contact the provider to gather additional clinical information. Then attempt to contact the case (regardless of whether contact was made with the provider). Please make three attempts to contact the case (text and phone calls) on separate days, at different times of the day (morning, afternoon, late afternoon). Document all attempts to contact a reporting source and/or reported case in the “Encounters” tab of EpiTrax. Please use the questions in EpiTrax to gather accurate information about the case. Focus on the key data elements listed below. If PDF CMR is used, the completed PDF version should be attached to the CMR in EpiTrax in the “Notes” tab. The CMR should be completed within 7 days of completing the investigation of the case.¹⁰

C. Step 3: Identify potential source of infection¹⁵

Efforts should be made to identify the source of infection for every confirmed case of measles. Case patients or their caregivers should be asked about contact with other known cases. When no history of contact with a case can be found, opportunities for exposure to unknown cases should be sought. Such exposures may occur in¹⁴:

1. Schools or daycares
2. During air travel
3. Through other contact with recent travelers or foreign visitors
4. While visiting tourist locations (casinos, resorts, theme parks)
5. Health care settings
6. Churches
7. Large indoor events

Unless a history of exposure to a known case within 7-21 days prior to the onset of rash in the case is confirmed, case-patients or their caregivers should be closely queried about all of these possibilities.



D. Step 3: Identify all contacts of case.

Due to the communicability of measles, anyone who had direct contact with the case is considered exposed along with anyone who was in the same room with a case for even a few minutes. Measles can linger in the air or settle on a surface for at least 2 hours after the infected person has left the room. Anyone who enters this enclosed space is considered exposed.

Identify rash onset date to determine infectious period. Case is considered infectious 4 days prior to rash onset through 4 days after onset.

Determine immunization status of each contact. Presumptive evidence of immunity includes:¹⁸

1. Written documentation of age-appropriate vaccination with a live measles-containing vaccine:
 - Preschool-aged children: 1 dose administered after the first birthday.
 - School-aged children (grades K-12): 2 doses; first administered after the first birthday and the second dose administered at least 28 days after the first dose.
 - Adults are not at high risk: 1 dose administered after the first birthday.
 - Adults at high risk (e.g., students in postsecondary education institutions, healthcare workers, international travelers): 2 doses; the first after the first birthday and the second dose administered at least 28 days after the first dose.
2. Laboratory evidence of immunity.
3. Laboratory confirmation of disease; or
4. Born before 1957.

E. Step 4: Initiate control measures for case and/or for contacts (see [Section IV](#) – [Section VI](#) below).

F. Step 5: Provide Education and Prevention messaging to the case and/or contacts (see [Section VII](#) below).

IV. CONTROL OF CASE^{14,15, 16}

1. All Cases

Person with suspected or confirmed illness should be advised to isolate during the contagious period, which is from onset of rash through 4 days after rash onset. This includes:

- Staying home and not going to public places or social activities, childcare, school or work. If immunocompromised, isolate throughout the duration of illness.
- Avoiding contact with susceptible children (particularly infants), pregnant women, and immunocompromised individuals.
- Avoiding contact with susceptible family members and visitors.
- Avoiding exposing others at healthcare facilities. Advise to call ahead and make arrangements with the facility to prevent contact with others.

2. *Management/Exclusions for Specific Groups or Settings*¹⁶

All Cases	
Sensitive Occupation*	- Exclude case or suspected case from work for four days after rash onset (day of rash onset is day 0), or for the duration of illness if the case or suspected case is immunocompromised. - Encourage documentation of immunity for employees in high-contact public-facing roles
Childcare/School Attendee	- Exclude case or suspected case from childcare facility for four days after rash onset (day of rash onset is day 0), or for the duration of illness if the case or suspected case is immunocompromised. On the same day that a report of a case having measles or suspected case considered to have measles in a school or childcare facility is received, the principal, director or other person in charge of the school or childcare facility shall: - Conduct an inquiry into absenteeism to determine the existence of any other cases of illness in the school or childcare facility. - Report the case or suspected case to the health authority. - Review the records of immunization of all enrolled children to identify those who are not adequately immunized against measles. - Notify the parent or legal guardian of each child who has not presented proof of immunity to measles, that the child is excluded from attendance at the school or childcare facility, effective the following morning: - Until acceptable proof of immunity to measles is received by the childcare facility or school; or - If the child has not been immunized to measles because of a medical or religious exemption, from the 5th day after the first exposure through the 21st day after the last exposure.
Case in a Medical Facility	- Work with HAI team to notify HCQC and inform the facility's Infection Preventionist (IP) about the case. Facility will determine precautions and restrictions. - Standard and airborne precautions are recommended for 4 days following rash

	onset or for the duration of illness in immunocompromised patients. • If a case or suspected case considered to have measles in a medical facility, the facility shall provide care to the case or suspected case in accordance with respiratory isolation or other appropriate disease specific precautions for at least 4 days after the onset of rash. • An employee of a medical facility shall not have direct contact with any case or suspected case unless the employee has provided proof of immunity to measles.
General Population	As a general precaution, individuals who believe they have measles should isolate themselves and seek medical care. This applies regardless of industry or occupation and helps ensure the safety and wellbeing of the community.

* A case having measles or a suspected case considered to have measles must be excluded from childcare facilities, schools, sporting events sponsored by schools, sensitive occupations, other occupations involving frequent contact with the public, public gatherings, and contact with susceptible persons outside of his or her household for at least 4 days after the onset of rash.

3. *Exclusion Notifications*

- Cases (non-immunocompromised): Isolate for ≥ 4 days after rash onset
- Cases (immunocompromised): Duration of isolation determined case-by-case in consultation with OSE and clinical experts
- Contacts without presumptive immunity may be excluded from high-risk settings (schools, healthcare, childcare) during the 7–21-day incubation period unless PEP is received and effective. Individuals receiving PEP in the form of immunoglobulin G (IG) may need to be excluded and monitored for up to 28 days after their last exposure because IG can prolong the measles incubation period.

V. CONTROL OF CONTACTS^{14,18,21}

Asymptomatic Contacts

1. For asymptomatic contacts with presumptive evidence of immunity to measles:
 - Exclusion from daily activities is not typically required.
 - Provide education about measles symptoms.
 - Instruct to monitor daily for prodromal symptoms followed by rash for at least 21 days from last exposure.
 - If symptoms develop, contact should isolate immediately and contact health care provider.

- Contacts with laboratory evidence of immunity (positive measles IgG from serum) can be considered to have evidence of preexisting immunity from prior vaccination or prior infection.
- 2. For asymptomatic contacts without presumptive evidence of immunity to measles:
 - Provide PEP as indicated. If PEP is provided, may not be required to quarantine and can continue normal daily activities (school, work, childcare).
 - If rash develops, contact should contact healthcare provider to differentiate between a vaccine reaction or a wild-type infection.
 - Healthcare providers can work with OSE and NSPHL to coordinate testing.
 - If contact does not receive PEP when there is no evidence of presumptive immunity, contact must quarantine away from others by staying home from school, work, and childcare. This also includes quarantining away from household members if possible.
 - Contacts in quarantine should monitor daily for symptoms for 21 days after last exposure. If any symptoms develop, contact needs to immediately isolate and contact healthcare provider. Testing can be coordinated through OSE and NSPHL.

Symptomatic Contacts

Investigate symptomatic contacts in the same manner as a case.

1. If contact is symptomatic, isolate until infectious period is over, or measles has been ruled out through testing. Suspect cases should avoid all contact with others until diagnosis is confirmed or ruled out. Symptomatic contacts should notify OSE and contact healthcare provider's office so special arrangements can be made to keep contact out of areas used by others.

Postexposure Prophylaxis (PEP)

Presumptive evidence of measles immunity should be assessed for all identified contacts. Use of postexposure prophylaxis (PEP), available either in the form of MMR vaccine or immunoglobulin (IG), may prevent or modify the clinical course of disease among exposed susceptible persons. It is important to keep in mind that estimates of PEP effectiveness are limited and mixed; effectiveness is dependent on the timing of PEP administration and the nature of the exposure.

High-priority groups for PEP include:

- Household members
- Immunocompromised individuals
- Pregnant people
- Infants <12 months
- School/daycare attendees and staff
- Healthcare workers

Use of MMR as PEP:

Administer within 72 hours of exposure to protect against or modify illness. Vaccination can still be offered after that for future protection. Doses of live vaccines should be spaced 28+ days apart. MMR as PEP is preferred for most healthy, susceptible individuals ≥ 6 months old.

- Susceptible individuals vaccinated within 72 hours of exposure may return to school or work (excluding healthcare settings).
- Infants under 12 months vaccinated with MMR for should follow the full routine immunization schedule (2 additional doses, ≥ 28 days apart).

Use of IG for PEP:

Administer within 6 days of exposure. IG comes in two forms intramuscular (IM) or intravenous (IV). MMR vaccine and IG should not be administered simultaneously as this invalidates the vaccine.

IG for PEP is generally recommended for:

- Infants < 6 months
- Severely immunocompromised individuals
- Pregnant individuals without evidence of immunity
- Intramuscular (IGIM) is usually preferred for infants < 12 months weighing < 30 kg (66lbs)
- Intravenous (IGIV) is reserved for high-risk susceptible individuals weighing ≥ 30 kg such as pregnant people without evidence of immunity or severely compromised individuals regardless of immunologic or vaccination status.

Dosing:

- IGIM: 0.5 mL/kg (max dose 15 mL)
- IGIV: 400 mg/kg

Susceptible people exposed to measles who receive IG may receive the MMR vaccine at the following intervals:

- No earlier than 6 months after IGIM administration
- No earlier than 8 months after IGIV administration

VI. MANAGEMENT OF SPECIAL SITUATIONS/OUTBREAK CONTROL

Coordinate with senior epidemiology staff to determine if an outbreak is occurring. If so, notify local health authorities, HCQC, or the Nevada State Immunization Program, as appropriate.

A. School and Childcare Settings^{6,15}

- Assess immunization status of staff, students and siblings who had contact with exposed students.

- Vaccinate staff and students who are exposed to and susceptible to measles. In outbreak situations, vaccination of siblings of students may also be considered as an expanded control measure.
 - Immune globulin may be administered instead of measles-containing vaccine. However, vaccination is the preferred method.
- Susceptible persons exposed to measles who receive MMR vaccine within 72 hours of exposure may return to school or childcare immediately (except in healthcare settings), with symptom monitoring.
 - However, people who receive immune globulin (IG) for measles PEP should not automatically be immediately readmitted in all settings, because IG can prolong the incubation period and may require extended monitoring and sometimes exclusion (up to 28 days, depending on setting and public health guidance).
- Susceptible persons who refuse vaccination must be excluded from school or childcare until at least the 22nd day has passed from the date of the onset of rash in the last case of measles identified in the school.
- Persons who develop symptoms of measles should be excluded from school or childcare for 4 days after rash onset or until measles is ruled out.
- Request that the school notify parents/guardians that a measles case has been identified in the school. A letter and measles fact sheet should be sent to each parent/guardian.

B. Health Care Settings^{15, 20}

- Assess the immunization status of all staff who may have been exposed, including people involved in direct patient care (e.g., nurses, physicians, phlebotomists) as well as people who work in the patient care setting (e.g., clerical staff, front office staff, technicians) or with exposure potential (e.g., laboratory staff, cleaning staff).
- Vaccinate people who are exposed and susceptible to measles.
 - Note: Persons born before 1957 are considered immune to measles. However, if they do not have documented evidence of immunity and have direct contact with patients or exposure potential, measles vaccination should be considered. Documentation of physician-diagnosed measles infection is not acceptable evidence of immunity for healthcare providers.
 - Immune globulin may be administered instead of vaccination. However, vaccination is the preferred method except in pregnant persons, immunocompromised persons, and those unable to receive MMR.
 - Healthcare personnel who receive IG as postexposure prophylaxis should be monitored for any signs and symptoms of measles from the 5th day after their exposure through the 28th day of their last exposure.
- Susceptible persons who are exposed, asymptomatic and have no immunity to measles should be excluded from direct patient contact and the affected medical facility from the 5th day after first exposure through the 21st day after last exposure, regardless of receipt of postexposure prophylaxis.

- Healthcare personnel who develop symptoms of measles earlier than the 5th day after their exposure, should be excluded from work pending further evaluation.
- Healthcare personnel with documentation of 1 vaccine dose may remain at work and should receive the second dose of MMR. They must monitor for symptoms daily through day 21.
- Susceptible people who develop symptoms of measles should be excluded from the facility for 4 days after rash onset.

VII. PREVENTION

To help prevent measles, it is important for cases and their contacts to:

- Receive MMR vaccination: The measles, mumps, and rubella (MMR) vaccine is the most effective way to protect against measles.
- Practice good hygiene: Regularly washing hands with soap and water and covering coughs and sneezes to avoid the spread of germs.
- Disinfect most touched surfaces: Measles can survive on surfaces for up to two hours, so regularly clean those high traffic surfaces.
- Stay at home when sick: If you or someone in your household shows symptoms of measles, stay at home to protect others from exposure. Call ahead to your doctor before you visit them so they can take proper infection control precautions.
- Avoid vulnerable populations such as pregnant women and newborn babies if experiencing a rash or fever.

Before traveling, individuals should ensure they are up to date on their MMR vaccinations. Additionally, exercise caution when traveling to states currently experiencing outbreaks.

VIII. REFERENCES

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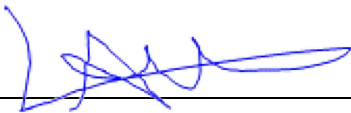
IX. ACKNOWLEDGEMENTS

This document was developed based on the content and format of the disease investigation guidelines of several state and local health jurisdictions:

- California Department of Public Health Investigation Quicksheets
- Oregon Health Authority Investigative Guidelines
- Washington State Department of Health Reporting and Surveillance Guidelines
- Washoe County Health District Epidemiology and Communicable Disease Program Investigation of Communicable Disease Manual

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X. UPDATE LOG



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4/30/26

Chief Medical Officer Approval Date