VARICELLA CARE GUIDE

March 2026

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to "Disclaimer Regarding Care Guides" for further clarification.

https://cchcs.ca.gov/clinical-resources/

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PURPOSE AND STRUCTURE

The California Correctional Health Care Services (CCHCS) Varicella Care Guide is a tool to aid leadership, the health care team, and other staff in the identification, notification, control, treatment, and prevention of chickenpox and shingles.

BACKGROUND

Varicella Zoster Virus (VZV) is a herpes virus that causes chickenpox (varicella or primary varicella), shingles (herpes zoster), and has the potential to cause morbidity and spread quickly throughout California Department of Corrections and Rehabilitation (CDCR) facilities. Timely recognition of illness and prompt initiation of appropriate infection control procedures is necessary to prevent disease transmission.

Chickenpox or primary VZV infection is a febrile vesicular rash illness. Prior to the introduction of the chickenpox vaccine in 1995, most people in the United States got chickenpox in childhood. Childhood infections are generally self-limited. Chickenpox in adults and immunocompromised children, can cause more severe disease. Infection with VZV is thought to confer lifelong immunity, but some individuals can get secondary cases after re-exposure, though generally these infections are much milder.

Following primary infection, the virus becomes dormant in the dorsal ganglia and can reactivate later causing shingles (herpes zoster). Shingles in immunocompetent individuals is characterized by a painful localized rash. According to the Centers for Disease Prevention and Control (CDC), approximately one third of persons in the United States will develop shingles in their lifetimes. Adults ≥50 years of age and immunocompromised people are at increased risk of developing shingles. The risk of developing shingles increases with age. Most people will only have shingles once in their lifetime, but it is possible to have additional episodes.

Patients who are immunocompromised are at increased risk for poor outcomes. For purposes of this care guide, immunocompromised includes persons with:

- organ or other transplants,
- aplastic anemia,
- histiocytosis,
- high risk HIV (CD4 count <250/mm^3, detectable viral load), or
- immunosuppression as defined in the patient registry, which includes cancer- and medication-related compromising conditions.

SECTION 1: CHICKENPOX AND SHINGLES TRANSMISSION, CLINICAL PRESENTATION, DIAGNOSIS AND PREVENTION

VZV infection is readily transmitted from person to person and anywhere from 70 to 90% of non-immune persons exposed to VZV will become infected. VZV may be transmitted by:

- Droplet Spread: when a person with chickenpox coughs or sneezes.
- Direct Contact: with upper respiratory secretions or with lesions that have not yet crusted.
- Airborne Spread: droplet nuclei (residue from evaporated droplets) or dust particles containing VZV can remain suspended in air for a few hours outside the body.
- Congenital Transmission: from mother to fetus.

For shingles, most VZV transmission occurs secondary to direct contact with lesion material. However, in immunocompromised persons with shingles, or in persons with disseminated shingles, transmission may occur via respiratory aerosols.

INCUBATION PERIOD

The incubation period for an infectious disease is the time period between exposure to the disease and the development of symptoms.

Chickenpox

The incubation period for chickenpox is 10–21 days from exposure to rash onset, most commonly 14–16 days. The incubation period may be up to 28 days in persons who have received varicella zoster immune globulin (VariZIG®) after an exposure and may be shortened in immunocompromised patients. Among neonates born to mothers with active infection, the incubation period can be as short as 2 days after birth.

Shingles

There is no incubation period for shingles because it is caused by a reactivation of the virus.

INFECTIOUS PERIOD

Chickenpox

The infectious period, i.e., when someone with chickenpox can spread infection, begins 48 hours prior to the onset of the first lesion and ends when all lesions are crusted (usually about 5 days).

Shingles

The infectious period for uncomplicated shingles begins at the time of rash onset and ends when all lesions are crusted and dried. A person is not infectious before vesicles (rash) appear. Persons with shingles do not transmit zoster (shingles) but can transmit VZV which can cause varicella in susceptible people. Covering the rash helps minimize the potential for transmission.

DIAGNOSIS

Clinical History

Chickenpox

Patients with chickenpox present with a generalized pruritic rash that starts as macules which then progress to papules then to vesicles followed by crusting. The rash develops after a prodrome that includes fever and malaise. Most patients have lesions at all stages of development at the same time. The rash usually appears first on the chest, back, and face, then spreads over the entire body. The lesions are usually most concentrated on the chest and back. Symptoms typically last 4 to 7 days. Persons who are vaccinated may develop a breakthrough infection—these patients tend to have fewer lesions and lesions may be atypical (maculopapular vs vesicular) with lesions involving the distal extremities.

Breakthrough chickenpox is a case of wild-type varicella infection that occurs in a vaccinated individual. Breakthrough chickenpox tends to be mild with shorter duration of illness, absence of fever and fewer than 50 skin lesions. Vaccinated persons with breakthrough varicella may also develop lesions that don't crust (macules/papules only). Such people should be isolated until no new lesions appear within a 24-hour period.

Infants, adolescents, adults, pregnant patients, and immunocompromised people are at risk for more severe disease including neurologic complications and pneumonia. In children, the most common complication is bacterial superinfection of the skin, mostly with group A streptococcus. In adults, the most common complication is pneumonia which can be very morbid. Other complications including encephalitis and other neurological complications, hepatitis, otitis media, and pharyngitis are well documented.

Immunocompromised patients are more likely to have more severe complications including encephalitis, pneumonia, disseminated disease (including hepatitis) and are at higher risk for death.

Shingles

Immunocompetent patients with shingles will present with a painful, vesicular localized rash in one or two contiguous dermatomes. These patients may present with pain prior to development of the characteristic rash.

A dermatome is an area or strip of skin supplied with afferent nerve fibers by a single posterior spinal root. Shingles lesions almost always appear on a strip of the skin over the infected nerve fibers and only on one side of the body. If non-adjacent dermatomes are affected this is considered disseminated shingles.

Complications of shingles include postherpetic neuralgia which is severe pain that persists after resolution of the rash. This is the most frequent complication and usually resolves within weeks but can persist for years. Other complications may include ophthalmic involvement which increases the risk for stroke, bacterial superinfection of the lesions, and cranial nerve palsy. Very rarely, meningoencephalitis, hepatitis, or pneumonitis may occur. Immunocompromised patients may present with disseminated diseases that affects three or more dermatomes.

SECTION 1: TABLE 1: VZV PRESENTATION AND SIGNIFICANT COMPLICATIONS

Disease	Complications
Chickenpox	• Encephalitis or other neurologic complications • Hepatitis • Pneumonia • Otitis Media • Pharyngitis • Bacterial superinfection (e.g., group A streptococcus)
Shingles	• Postherpetic neuralgia • Ophthalmic involvement may increase risk for stroke • Cranial nerve palsy • Meningoencephalitis (rare) • Bacterial superinfections • Hepatitis • Pneumonitis • Disseminated disease

LABORATORY TESTING

In the community, most diagnosis is clinical, but laboratory testing may be used to confirm VZV. For CCHCS patients, the preferred method is PCR.

Providers should utilize the test Varicella Zoster Virus, DNA Qual PCR, which is a qualitative assay. For collection, handling, and storage information for specimens please reach out to Quest diagnostic lab for specific instructions. Health care staff should wear appropriate personal protective equipment to collect the specimen.

Other testing including serology or culture is generally not useful in these situations.

PREVENTION - VACCINATION

Chickenpox Vaccine

Persons without documentation of two doses of varicella vaccination, or a positive varicella serology, should be offered vaccination. Full vaccination requires 2 doses given 4 to 8 weeks apart. If it has been more than 8 weeks since the first dose, the second dose may be given without restarting the schedule series.

Varicella vaccine or Varivax, is a live virus vaccine and therefore there are several contraindications for administration, including pregnancy and immunosuppression. Please see Appendix A for Vaccine Contraindications.

Shingles Vaccine

Persons 50 years of age and older:
As adapted from the CDC guidelines, two doses separated by 2 to 6 months of Shingrix (recombinant zoster vaccine, or RZV) should be given to immunocompetent adults aged 50 years and older:

- Whether or not they report a prior episode of herpes zoster.
- Whether or not they report a prior dose of Zostavax, a shingles vaccine that is no longer available for use in the United States.
- Persons who never had chickenpox but were vaccinated for varicella should also be vaccinated for shingles.

Vaccination of Immunocompromised Adults 19 Years and Older
CDC recommends two doses of RZV for the prevention of shingles and related complications in adults aged ≥19 years who are or will be immunocompromised because of disease or therapy. The second dose of RZV should typically be given 2–6 months after the first. However, for persons who are or will be immunocompromised and who would benefit from completing the series in a shorter period, the second dose can be administered 1–2 months after the first. For further information please see Clinical Considerations for Shingrix Use in Immunocompromised Adults Aged ≥19 Years | Shingles (Herpes Zoster) | CDC

SECTION II: CASE MANAGEMENT AND ISOLATION

Patients with suspected or confirmed chickenpox or shingles need to be placed on a medical hold, provided education, isolated from others with transmission-based precautions, and monitored daily.

CLINICAL MONITORING DURING ACUTE ILLNESS

Patients with chickenpox or shingles should be monitored daily to ensure that complications are managed quickly, and patients can be moved to higher levels of care (HLOC) if needed. Patients with ophthalmic zoster or other rash in the trigeminal nerve distribution (nose, forehead, periorbital region) should have urgent consultation with an ophthalmologist or be transferred to the acute care hospital given possibility of vision loss.

SECTION II: TABLE 1. ISOLATION, PRECAUTIONS, PERSONAL PROTECTIVE EQUIPMENT (PPE), CLINICAL MONITORING, AND RELEASE FROM ISOLATION FOR VZV CONDITIONS

	Chickenpox	Disseminated Shingles	Localized Shingles, Immunocompromised Host	Localized Shingles, Immunocompetent Host
Isolation	Yes, in AIIR	Yes, in AIIR	Yes, AIIR not required	Yes, AIIR is not required if localized
Transmission-based Precautions	Airborne, contact	Airborne, contact	Contact	Contact
PPE	Gown, gloves, eye protection, N95 or equivalent	Gown, gloves, eye protection, N95 or equivalent	Gown, gloves	Gown, gloves
Vital Sign Monitoring	Yes	Yes	No	No
Symptom Monitoring	Pain, status of rash, ask patients about facial lesions/location of rash	Pain, status of rash, ask patients about facial lesions/location of rash	Pain, status of rash, ask patients about facial lesions/location of rash	Pain, status of rash, ask patients about facial lesions/location of rash
Release from Isolation	All lesions crusted and at least five days from rash onset	All lesions crusted and at least five days from rash onset	All lesions crusted and at least five days from rash onset	All lesions crusted and at least five days from rash onset

TREATMENT

Chickenpox

As adult patients with chickenpox have a higher risk for complications, treatment with antiviral therapy (generally valacyclovir 1 gram three times a day or acyclovir 800 mg five times a day) should be prioritized in addition to supportive therapy, especially for immunocompromised patients or pregnant patients. Note that it is often preferred for immunocompromised patients to be treated with intravenous acyclovir and given risk for pneumonia, hepatitis, and encephalitis, these patients may be initially best managed at higher levels of care.

Shingles

Patients with shingles should also be offered antivirals—all patients who present within 72 hours of rash onset should be offered antivirals (valacyclovir or acyclovir). Some patients who present >72 hours (e.g., immunocompromised patients, pregnant patients), may also benefit from antiviral therapy and should be managed closely by the provider. Additionally, patients should be encouraged to keep lesions covered with a non-occlusive sterile bandage.

Please note that patients with chronic kidney disease may require dose adjustments. Please see additional clinical resources like UpToDate for more details on treatment regimens.

ISOLATION

Chickenpox and Disseminated Shingles or Shingles in Immunocompromised Patient:

The patient should be isolated in an airborne infection isolation room (AIIR) with airborne and contact precautions instituted. If AIIR is not available at the institution, the patient should be transferred to another institution or outside of CDCR as needed. The patient should wear a surgical mask while awaiting transfer, during transport, and during any interviews.

If it is later determined that immunocompromised patients with shingles have only localized disease, they may be managed as per localized shingles in an immunocompetent host.

All health care and custody staff, volunteers, or incarcerated workers entering the cell or hospital room of a patient should wear a NIOSH certified N95 or powered air-purifying respirators (PAPRs).

Localized Shingles in Immunocompetent Host:

The patient should be isolated in a single cell with a closed door, which can be within the general population. AIIR is not needed but the patient should be placed on contact precautions. If the patient requires housing in the medical unit (e.g., there are no single cell rooms in the general population), care should be taken to ensure that the patient is housed separate from immunocompromised and non-immune patients.

For all patients, make sure door signage or other posting warns staff who are not immune to chickenpox to avoid contact with the isolated patient to prevent transmission of chickenpox disease.

Release from Isolation
For both chickenpox and shingles, the patient should remain in isolation until all lesions have crusted over and it has been at least five days from rash onset.

The goal of investigation for VZV disease is to identify and isolate infected patients and to prevent the transmission of chickenpox disease to non-immune individuals. These guidelines include information on communication, quarantine, outbreak containment, contact investigations, and post-exposure vaccinations/prophylaxis.

VARICELLA IMMUNITY

Immunity is defined as a documented history of varicella, a positive immunoglobulin G with positive serology, or completion of the vaccine series. Individuals with immunity are protected from VZV transmission. Persons without immunity should be excluded from working in the quarantine area. For employee questions regarding VZV immunity please contact the Employee Health Program.

SECTION III: OUTBREAK INVESTIGATION AND MITIGATION

NOTIFICATION AND REPORTING

When a health care practitioner identifies a patient with suspected chickenpox or shingles, they should immediately notify the Chief Medical Executive (CME), Chief Nursing Executive (CNE), Public Health Nurse (PHN), Infection Control Nurse (ICN), and custody partners. The Employee Health Program should be notified by the PHN and/or ICN.

Reporting to Headquarters Public Health

Chickenpox: the PHN should contact the Headquarters Public Health/Infection Control Nurse Consultant Program Reviewer (NCPR). A Public Health Outbreak Response System (PORS) report should also be submitted.

Shingles: The PHN, or designee, should submit a PORS report.

Communicable Disease Reporting to the Local Health Department

Chickenpox: As outlined in HCDOM Section 3.8.1, Public Health Disease Reporting, reportable diseases shall be reported to the local health officer. This includes outbreaks of chickenpox or any deaths associated with varicella.

Shingles: Shingles is not reportable to the local health officer.

OUTBREAK MANAGEMENT MEETINGS

Investigations should involve a coordinated, multi-disciplinary outbreak team that may include the following depending on the circumstances of the outbreak:

- Chief Executive Officer of Health Care
- CME
- CNE
- PHN
- ICN
- Custody partners including Warden or designee, Associate Warden of Health Care, and other key custody staff
- Employee Health Program
- Pharmacist in Charge or designee
- Laboratory supervisor if multiple contacts will require lab draw to assess for immunity
- Environmental Services Manager to ensure timely notification of additional cleaning requirements or potential exposures

After the identification of a patient with chickenpox, or for patients with disseminated shingles, the outbreak management team should convene an outbreak control meeting. CCHCS Headquarters Public Health will convene the initial call. This meeting should include review of the following:

- Number of patients ill
  - Number currently symptomatic
  - Isolation procedures (please see Section II)
  - Any hospitalizations or deaths
  - Number of patients tested
  - Results of testing
- Number of housing units affected
- Housing unit status
- Infection control measures
- Employee health concerns
- Communication to staff and residents about chickenpox: memos, signage, communication with incarcerated persons advisory committee (IAC)

Over the course of the outbreak, it may be necessary to convene similar meetings to discuss the course of the outbreak and determine if additional control measures are required.

CONTACT INVESTIGATION

After notification that there is a patient with suspected chickenpox or shingles (e.g., the index case or the first person ill with infectious chickenpox or shingles), the outbreak team should begin an investigation. The goal of the investigation is to identify all contacts (persons exposed to the index case while the index case was infectious), determine the exposure period, determine immune status of contacts, and begin preparations for post-exposure prophylaxis and notifications as needed. The exposure period is 48 hours prior to rash onset until the index case is isolated for chickenpox or disseminated shingles, and date of rash onset to isolation for localized shingles. Note that during all interviews of the index patients, only health care staff (PHN, ICN, other practitioners) with immunity to varicella should interact with the patient.

Appendix B is the Varicella Line List which should be utilized to manage and follow contacts throughout the investigation process.

Appendix C is the Varicella Contact Investigation Timeline Calculator to calculate exposure, infectious, and incubation periods.

Appendix D outlines all steps to be completed for a contact investigation including how to determine if a patient has a significant exposure and requires quarantine or placement on a medical hold.

POST-EXPOSURE PROPHYLAXIS

In partnership with pharmacy colleagues, appropriate post-exposure prophylaxis should be offered to non-immune contacts.

Vaccination: Immunocompetent non-pregnant persons only

Ideally, varicella vaccine should be administered to non-immune, exposed contacts within 3 days of exposure, and ordinarily no more than 5 days after varicella exposure. If administered within this time frame, vaccine can prevent chickenpox. Vaccine is still indicated for susceptible (non-immune) incarcerated persons after this window period as it can interrupt transmission during an ongoing outbreak even if given more than 5 days after initial exposure. More importantly, vaccination confers future immunity to help prevent chickenpox among incarcerated people.

Varicella vaccine is a live vaccine and should not be administered to pregnant patients or HIV-infected persons with CD4 <200 mg/dL. See Appendix A Varicella Vaccine Contraindications for more information.

Varicella Immune Globulin: Immunocompromised and pregnant patients

Varicella immune globulin (VariZIG®) is a purified human immune globulin made from plasma containing high levels of anti-varicella antibodies. The CDC recommends that VariZIG® be administered post-exposure for high-risk contacts including pregnant patients and immunocompromised patients. It should be administered as soon as possible and within 10 days of first exposure to:

- Immunocompromised persons without evidence of varicella immunity
- Pregnant patients without evidence of varicella immunity

Antiviral post-exposure prophylaxis (PEP) for healthy exposed, susceptible persons is not routinely recommended, however, acyclovir as PEP may be considered.

MEDICAL HOLD FOR CONTACTS

Chickenpox or disseminated shingles (or shingles in an immunocompromised host):

Place all persons without evidence of immunity from affected housing unit(s) on a medical hold for the entire quarantine period. The primary care provider (PCP) should place a medical hold on all the contacts by completing the medical classification chrono (MCC), so they are not sent to other correctional facilities. They should remain in their current housing unit, to the extent possible, until their immunity status has been determined. If it is later determined that they have immunity, the medical hold may be discontinued.

Localized Shingles including immunocompromised host if truly localized:

Contacts without evidence of immunity and with a significant exposure should be placed on medical hold. If it is later determined that contacts have immunity, they may be released from the medical hold.

QUARANTINE

Quarantine is the separation of contacts from other persons who are not contacts. Contacts to chickenpox or shingles who do not have evidence of immunity should be educated and placed on quarantine to include daily rounding. Initiate transmission-based precautions immediately if symptoms are reported.

Please see Appendix C, Varicella Contact Investigation Timeline Calculator to determine dates of quarantine for all contacts. In general, contacts are quarantined until day 21 post-exposure (day 28 if they receive Varizig). Persons placed in quarantine should be educated on what to expect while in quarantine, what symptoms to monitor for, how to request assistance, and how long they will be in quarantine (Patient Education Sheets).

Restrictions and Privileges While on Quarantine:

- All contacts in quarantined unit(s) should continue to have yard privileges separate from those not on quarantine.
- Restrict them from inter-mingling with non-exposed individuals in yards, classrooms, clinics, schools, work, dining halls, and visiting.
- Arrange for quarantined individuals to be fed together in a chow hall in a group by themselves (as the last group). If this is not possible, feed them in their cells or housing units until they come off the quarantine list.
- Non-quarantined, non-immune incarcerated persons should generally not be admitted to the housing unit after quarantine has been established, but if that is not possible, they should be screened for chickenpox immunity PRIOR to being housed in that unit. Only known immune incarcerated people can be housed there during the quarantine period.

Monitoring Contacts on Quarantine

Susceptible, quarantined contacts should be assessed DAILY by nursing staff for signs and symptoms of chickenpox which may include a temperature check and asking about rash. Patients should be educated on signs and symptoms and encouraged to alert health care providers if they develop any signs or symptoms. Adults with chickenpox may develop general malaise (e.g., feeling severe fatigue, or ill) 1–2 days prior to rash onset. If any of these contacts develop symptoms including rash consistent with chickenpox, the patient should be masked and isolated immediately in an airborne infection isolation room (AIIR) and evaluated by a health care provider.

Staff should wear appropriate personal protective equipment (PPE) as follows:

- While rounding on contacts to include the use of an N95 and contact precautions.
- People who will be within 3–6 feet of a contact (such as for surveillance rounding, face-to-face interviews, or escorts) should wear N95.
- Quarantined Housing unit workers: N95 are encouraged but not necessarily mandatory
- People who are pregnant or immunocompromised should be excluded from working in Quarantine and Isolation zones.

INFECTION PREVENTION AND CONTROL

Precautions

Airborne precautions require the use of an N95 respirator or powered air-purifying respirator (PAPR) when entering the AIIR or within close proximity of the patient when outside of the AIIR. Patients should wear surgical face masks when outside of the AIIR.

Contact precautions require a gown and gloves for any direct contact with the patient, open lesions, or care environment such as bed rails, linens, etc.

N95s are not required within the quarantine unit, however, if in close contact (e.g., vitals, custody escort, etc.) with a quarantined individual, an N95 should be worn.

Chickenpox and disseminated shingles or shingles in immunocompromised host

All patients with suspected or confirmed chickenpox or disseminated shingles should be isolated in an AIIR and placed on standard, contact, and airborne precautions.

Localized shingles

Patients with localized shingles should be Isolated and placed on standard and contact precautions.

Personal Protective Equipment

Health care and custody staff caring for patients, porters, and other staff in contact with ill patients or responsible for cleaning should wear appropriate PPE. All staff should perform hand hygiene prior to donning and after doffing PPE. This includes persons who are performing surveillance quarantine rounds.

Chickenpox and disseminated shingles: Airborne precautions plus contact precautions.

Localized shingles: Contact precautions.

Cleaning Isolation Rooms

The isolation room should be terminally cleaned by staff wearing the appropriate PPE using an Environmental Protection Agency registered disinfectant including Cell Block 64 or other disinfectant which has virucidal activity against enveloped viruses.

COMMUNICATIONS

Memos and other communications including patient education should be provided to staff and incarcerated persons who may have been exposed. These communications should alert them to the exposure, discuss what signs and symptoms they should be monitored for, and provide information on vaccination. Please see Appendices E-H for communication memos and patient education materials in PE-1 - PE-6.

SECTION IV: REFERENCES

CDCR/CCHCS Resources

- Health Care Department of Operations Manual, Section 3.8.1, Public Health Disease Reporting

CDPH Resources

- Varicella Quicksheet (ca.gov)
- CDPH Varicella Healthcare Exposure Quicksheet
- Zoster Quicksheet (ca.gov)

CDC Resources

- Varicella - Vaccine Preventable Diseases Surveillance Manual | CDC
- ACIP Recommendations: Varicella (Chickenpox) Vaccine | ACIP Recommendations | CDC
- ACIP Zoster Vaccine Recommendations | Shingles | CDC

Other Resources

- Federal Bureau of Prisons Varicella Zoster (bop.gov)

Patient Education

- About Chickenpox | CDC
- About Shingles (Herpes Zoster) | CDC

Appendix A. Varicella Vaccine Contraindications

Varivax is a live virus chickenpox vaccine. Therefore, it is contraindicated for a patient who:

- Is or may be pregnant
- Has a history of anaphylactic/anaphylactoid reaction to gelatin, neomycin, or any other component of the vaccine
- Has blood dyscrasias, leukemia, lymphomas, or malignant neoplasms affecting bone marrow or the lymphatic system
- Has a primary or acquired immunodeficiency, including persons with immunosuppression associated with cellular immunodeficiencies and AIDS or severe immunosuppression associated with HIV infection
- Is receiving prolonged, high-dose systemic immunosuppressive therapy (≥2 weeks), including large doses of oral steroids (≥2mg/kg of body weight or a total of 20mg/day of prednisone) or other immunosuppressive therapy
- Has a moderate or severe concurrent illness
- Has a family history (first degree relatives) of congenital hereditary immunodeficiency, unless the person has been determined to be immunocompetent

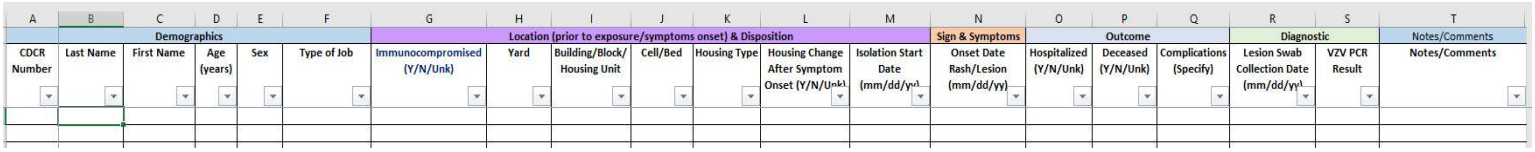
In addition, MMRV vaccine is contraindicated for people with impaired humoral immunity (hypogam-maglobulinemia, dysgammaglobulinemia) and HIV infection

Please see the Centers for Disease Control and Prevention Varicella Vaccine Recommendations | CDC for more information on contraindications.

Appendix B. Varicella Line List

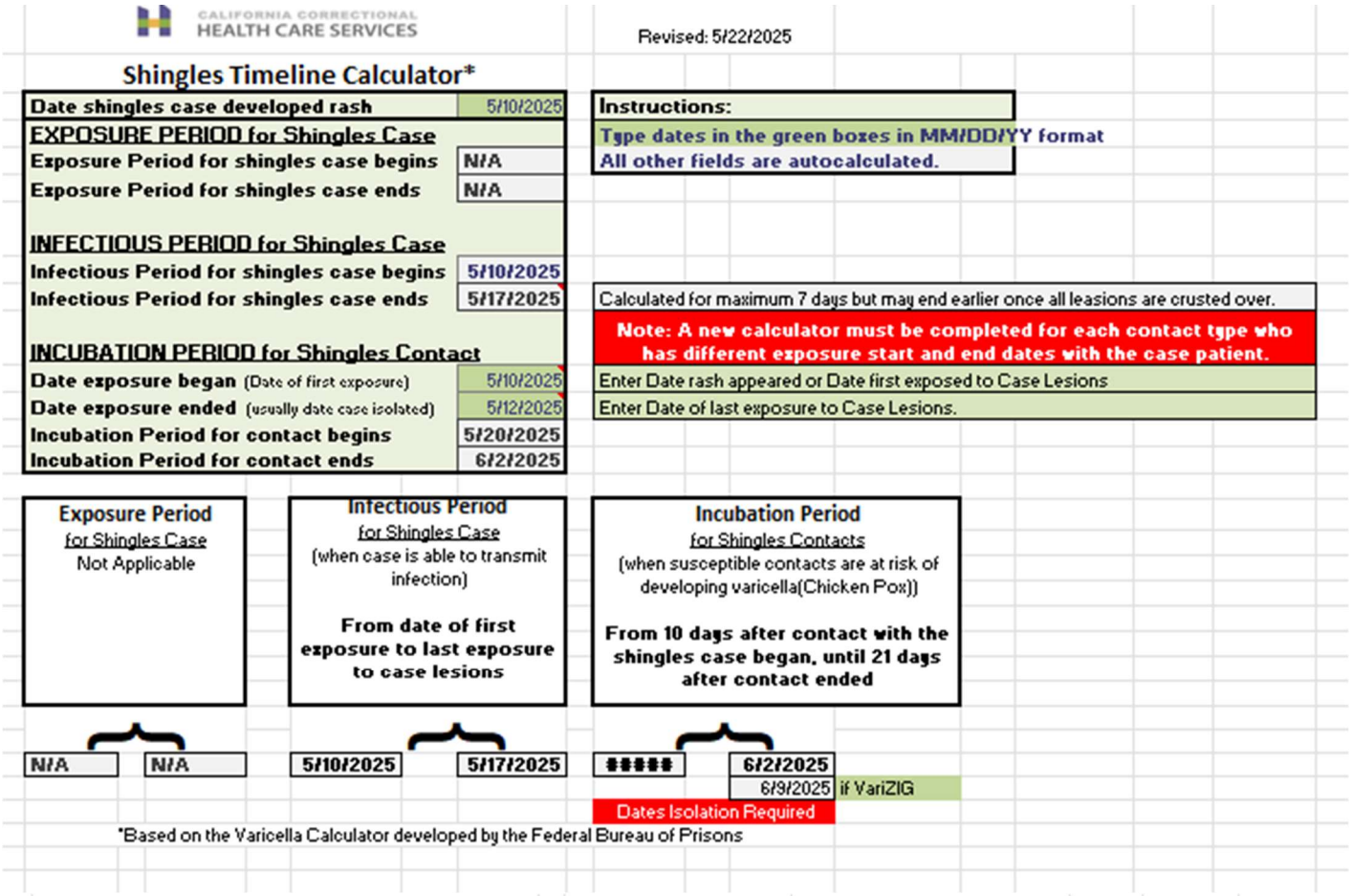
[Varicella Line List Excel File]

Click the link to the file > File > Create a Copy > Download a Copy > Open downloaded file > Hit enable editing > Save the file in your folder/share point folder/One Drive Folder. Then work on the saved file.



	Demographics					Location (prior to exposure/symptoms onset) & Disposition							Sign & Symptoms	Outcome			Diagnostic		Notes/Comments
CDCR Number	Last Name	First Name	Age (years)	Sex	Type of Job	Immunocompromised (Y/N/Unk)	Yard	Building/Block/ Housing Unit	Cell/Bed	Housing Type	Housing Change After Symptom Onset (Y/N/Unk)	Isolation Start Date (mm/dd/yy)	Onset Date Rash/Lesion (mm/dd/yy)	Hospitalized (Y/N/Unk)	Deceased (Y/N/Unk)	Complications (Specify)	Lesion Swab Collection Date (mm/dd/yy)	VZV PCR Result	Notes/Comments

Appendix C. Varicella Contact Investigation Timeline Calculator



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Revised: 5/22/2025

Shingles Timeline Calculator*

Date shingles case developed rash	5/10/2025
EXPOSURE PERIOD for Shingles Case	
Exposure Period for shingles case begins	N/A
Exposure Period for shingles case ends	N/A
INFECTIOUS PERIOD for Shingles Case	
Infectious Period for shingles case begins	5/10/2025
Infectious Period for shingles case ends	5/17/2025
INCUBATION PERIOD for Shingles Contact	
Date exposure began (Date of first exposure)	5/10/2025
Date exposure ended (usually date case isolated)	5/12/2025
Incubation Period for contact begins	5/20/2025
Incubation Period for contact ends	6/2/2025

Instructions:
Type dates in the green boxes in MM/DD/YY format
All other fields are autocalculated.

Calculated for maximum 7 days but may end earlier once all leasions are crusted over.

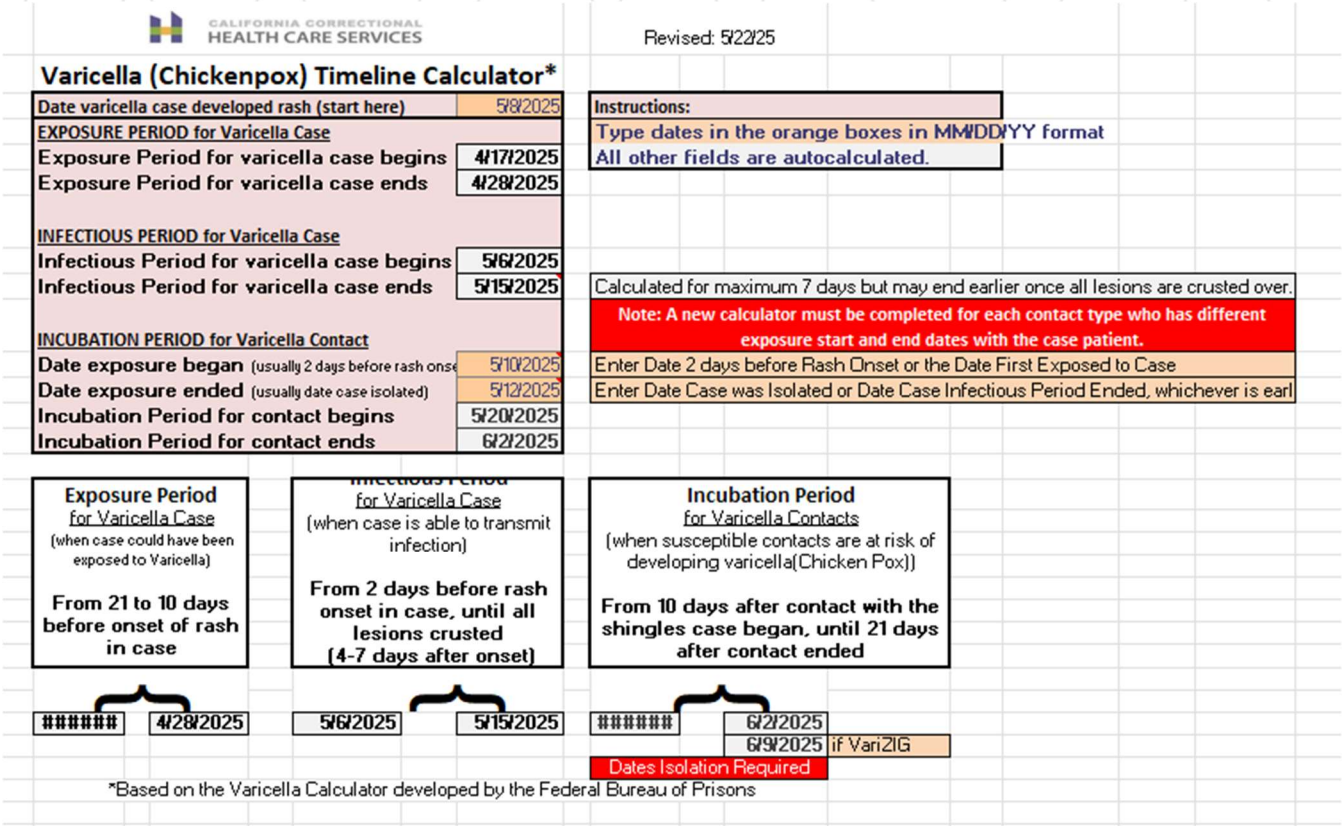
Note: A new calculator must be completed for each contact type who has different exposure start and end dates with the case patient.

Enter Date rash appeared or Date first exposed to Case Lesions

Enter Date of last exposure to Case Lesions.

Exposure Period for Shingles Case	Infectious Period for Shingles Case	Incubation Period for Shingles Contacts
Not Applicable	(when case is able to transmit infection)	(when susceptible contacts are at risk of developing varicella(Chicken Pox))
	From date of first exposure to last exposure to case lesions	From 10 days after contact with the shingles case began, until 21 days after contact ended
N/A – N/A	5/10/2025 – 5/17/2025	##### – 6/2/2025
		6/9/2025 if VariZIG
		Dates Isolation Required

*Based on the Varicella Calculator developed by the Federal Bureau of Prisons



CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

Revised: 5/22/25

Varicella (Chickenpox) Timeline Calculator*

Date varicella case developed rash (start here)	5/8/2025
EXPOSURE PERIOD for Varicella Case	
Exposure Period for varicella case begins	4/17/2025
Exposure Period for varicella case ends	4/28/2025
INFECTIOUS PERIOD for Varicella Case	
Infectious Period for varicella case begins	5/6/2025
Infectious Period for varicella case ends	5/15/2025
INCUBATION PERIOD for Varicella Contact	
Date exposure began (usually 2 days before rash onse	5/10/2025
Date exposure ended (usually date case isolated)	5/12/2025
Incubation Period for contact begins	5/20/2025
Incubation Period for contact ends	6/2/2025

Instructions:
Type dates in the orange boxes in MM/DD/YY format
All other fields are autocalculated.

Calculated for maximum 7 days but may end earlier once all lesions are crusted over.

Note: A new calculator must be completed for each contact type who has different exposure start and end dates with the case patient.

Enter Date 2 days before Rash Onset or the Date First Exposed to Case

Enter Date Case was Isolated or Date Case Infectious Period Ended, whichever is earl

Exposure Period for Varicella Case	Infectious Period for Varicella Case	Incubation Period for Varicella Contacts
(when case could have been exposed to Varicella)	(when case is able to transmit infection)	(when susceptible contacts are at risk of developing varicella(Chicken Pox))
From 21 to 10 days before onset of rash in case	From 2 days before rash onset in case, until all lesions crusted (4-7 days after onset)	From 10 days after contact with the shingles case began, until 21 days after contact ended
###### – 4/28/2025	5/6/2025 – 5/15/2025	###### – 6/2/2025
		6/9/2025 if VariZIG
		Dates Isolation Required

*Based on the Varicella Calculator developed by the Federal Bureau of Prisons

[Varicella and Shingles Timeline Calculator Excel File]

Appendix D. Varicella Contact Investigation Steps and Public Health Nurse Checklist

These contact investigation steps were developed to assist the public health teams at the institution in the event of a suspected case of varicella. Investigation steps (1-4) include determining the exposure period, identifying contacts, determining immunity status of contacts, and identifying which contacts are immunocompromised. Mitigation steps (5-11) include education, quarantine and monitoring of non-immune contacts, post-exposure prophylaxis, and isolation of symptomatic patients.

Step 1: Identification of the Potential Exposure Period

The infectious period should be determined. In general, the exposure period should be considered to start 48 hours prior to the index patient's rash onset and end when the index patient is isolated for chickenpox or disseminated shingles. An exposure period for patients with localized shingles only includes date of rash onset until isolation.

Step 2: Identification of Contacts

The index patient should be interviewed to identify any contacts with significant exposure as defined below. In addition, the Strategic Oversight Management System (SOMS) should be reviewed to identify any movement inside and outside the facility. Close attention should be paid to potential contacts in classrooms, clinics, or workspaces, and other activities by reviewing the Patient Contact Tracing quality management tool and the patient interview. The Employee Health Program should be notified of areas where the index case may have spent time to develop their own staff contact list.

Appendix D Table 1. Significant Exposure Table

Disease	Contact with Non-Crusted Lesions	Sharing Indoor Airspace with Infectious Person (no precautions)	Cellmates/dormmates
Chickenpox	X	X	X
Shingles disseminated or immunocompromised patient (and unknown if localized)	X	X	X
Shingles localized	X		• Those sleeping up to 2 bunks in any direction to patient. • If lesions uncovered for >24 hours may consider all persons in housing unit exposed.*

*Please consult with CCHCS Headquarters Public Health.

Chickenpox

A significant exposure to chickenpox is defined as any person who has had:

- Unprotected skin to skin contact with the index patient when they had a rash.
- Contact with Naso-pharyngeal secretions from the index case.
- One hour sharing indoor space, e.g., classroom, friends, groups, workspace.
- Exposure to the index case in an entire housing unit(s) where the index case was housed while infectious.

Appendix D, Cont'd

Disseminated shingles or immunocompromised patient

A significant exposure to disseminated shingles, or exposure to an immunocompromised person with shingles, is defined as:

- Contact with lesions, e.g., via close patient care, touching, or hugging.
- Sharing indoor airspace with the infectious person (e.g., occupying the same room) for any length of time. If contact and airborne precautions were being implemented, it is not an exposure.

Localized shingles

A significant exposure to localized shingles is defined as:

- Contact with a non-crusted lesion, e.g., during patient care, touching, or hugging. If contact precautions were being implemented (i.e., if lesions were completely covered with clothing or dressing), it is not considered an exposure.
- Cellmates and dormmates: consider significant exposure as incarcerated persons sleeping up to 2 bunks in any direction to the case patient. Or cellmates/dormmates in a housing area if the case patient is unable to cover lesions (e.g., facial lesions) for >24 hours.

Create a list of all incarcerated persons exposed to the index case (See Appendix B: Varicella Line List).

Step 3: Determining Immunity Status for Contacts

To assist with determination of immune status, the outbreak team may request a line list of contacts from Quality Management (QM) documenting immunity. Patients with a positive serology or history of 2 doses of varicella vaccine are considered immune. Patients who have received 2 doses of vaccine should not have titers checked. Non-immune contacts should be placed in quarantine.

Non-immune contacts should the immunity ACIF test performed, or have serology (IgG), to determine prior immunity. PHNs or providers may consider alerting laboratory staff to prioritize these draws. Serologic testing for immunity is useful in the context of a chickenpox outbreak to test those who do not meet the immunity criteria, e.g., documented history of varicella vaccine (2 doses), a documented history of chickenpox or shingles by a health care provider, or laboratory evidence of immunity. Please note, additional vaccine information may be available through the California Immunization Registry (CAIR) and should be queried if contacts state that they have been previously vaccinated but no documentation is available within the electronic health record system.

A positive IgG result indicates that a person has antibody to VZV but does not differentiate between an active or past infection. The commercially available varicella IgG assays reliably measure immunity due to previous infection but may not be sensitive enough to detect antibodies induced by vaccination. The immunity ACIF test is much more sensitive for individuals with history of vaccination. A negative IgG result in a vaccinated individual does not necessarily indicate susceptibility to VZV infection. Any patient with a history of 2 doses of varicella vaccine should not have titers drawn. If these patients do have titers drawn with a negative serology, they should still be considered immune.

As more information returns (e.g., vaccine records, serology), those found to be immune may be removed from the initial contact list and removed from quarantine. Those who are non-immune should remain quarantined during the entire quarantine period.

Step 4: Identifying Immunocompromised Contacts

In addition to identifying individuals who are susceptible to varicella, this line list can also be utilized to identify patients who are immunocompromised as defined in Background.

Step 5: Notify the pharmacist and prepare for vaccination or other post-exposure prophylaxis for non-immune contacts.

Appendix D, Cont'd

Step 6: Notification and Education of Affected Staff and Incarcerated Persons

In the event of an outbreak the institution should notify the incarcerated population of a possible exposure, signs, and symptoms to watch for, and possible post-exposure prophylaxis for individuals without immunity.

A memo may be created by the institution's leadership to alert staff and volunteers of a possible exposure and to follow up with the Employee Health Program should a staff or volunteer person develop symptoms. The memo should include discussion of risks of chickenpox in pregnancy and to request that any pregnant staff or volunteers follow up with their physician to consider post-exposure prophylaxis as needed. Templates for memo communications can be found in Appendices E-H.

Step 7: Determining the Quarantine Period for Contacts

Exposed incarcerated contacts who are non-immune require quarantine. The timing of quarantine is based on when contacts can be expected to develop disease.

- Quarantine start date: Begins 10 days after the first exposure to the index case. In most instances, many contacts can have immunity status assessed prior to requiring quarantine.
- Quarantine end date: 21 days after last exposure to index case, unless contact received immunoglobulin then end date will be 28 days after last exposure to index case (see Appendix C Varicella Contact Investigation Timeline Calculator).
- Please see details within Step 9, Appendix D. Table 2, Vaccination Status, Serology, and Quarantine.

Step 8: Placing Contacts on Medical Hold and Quarantine

Non-immune contacts on quarantine should be placed on a medical hold. While contacts are on quarantine, they should be monitored to ensure they do not develop symptoms. If any contacts develop symptoms, they should be placed in isolation and treated as a case. Please see Section III Outbreak Investigation and Mitigation, E. Medical Hold and F. Quarantine for more information.

Step 9: Offer Post-Exposure Prophylaxis to Patients Exposed

Ideally, varicella vaccine should be administered to non-immune, exposed contacts within 3 days of exposure, and ordinarily no more than 5 days after varicella exposure. If administered within this time frame, vaccine can prevent chickenpox. Vaccine is still indicated for susceptible (non-immune)patients after this window period as it can interrupt transmission during an ongoing outbreak even if given more than 5 days after initial exposure. More importantly, vaccination confers future immunity to help prevent chickenpox among patients.

Varicella vaccine is a live vaccine and should not be administered to pregnant patients or HIV-infected persons with CD4 <200 mg/dL. In that instance, varicella immune globulin (VariZIG®) may be used. This is a purified human immune globulin made from plasma containing high levels of anti-varicella antibodies. CDC recommends that VariZIG® be administered post-exposure for high-risk contacts including pregnant patients and immunocompromised patients. It should be administered as soon as possible and within 10 days of first exposure to:

- Immunocompromised persons without evidence of varicella immunity
- Pregnant patients without evidence of varicella immunity

Appendix D. Table 2 Vaccination Status, Serology, and Quarantine

Under These Conditions		Recommended Actions	
Documented Vaccination Status Prior to First Exposure	**One Vaccine Dose Within 5 Days After First Exposure?**	**Offer Serology?**	**Quarantine and Additional Vaccine Needed?**
Two doses adequately spaced varicella vaccine documented	Not needed	No	No quarantine needed.
Only one dose varicella vaccine documented	Yes	No	No quarantine/may remove from quarantine
Only one dose varicella vaccine documented	No	Yes	**If serology positive**, may remove from quarantine. **If serology negative**, contact to remain in quarantine for the duration and **should be offered second dose of vaccine**.
No vaccine documented	Yes	Yes	**If serology positive**, may remove from quarantine. **If serology negative**, contact to remain in quarantine for the duration **and should be offered second dose of vaccine**.
No vaccine documented	No	Yes	**If serology positive**, may remove from quarantine. **If serology negative**, contact to remain in quarantine for the duration and **should be offered vaccination series** (two doses, 28 days apart).

Step 10: Isolate symptomatic contacts

If any contact becomes symptomatic, they should be immediately placed in isolation and treated as a suspect varicella case.

Step 11: Conclusion of Monitoring Period

At the end of the monitoring period, based on the exposure period determined in step 1, the institution PHN should send the final line list to CCHCS Public Health.

Appendix D, Cont'd

Varicella (Chickenpox) Contact Investigation
Public Health Nurse Checklist
Public Health Branch Warmline: (916) 691-9901

Check: X when completed		The PHN checklist is a tool to be used when a varicella (chickenpox) contact investigation has been advised by the Local Health Department (LHD) Health Officer and the CCHCS Public Health (PH). Correctional facility PHNs should focus their contact investigation on incarcerated persons, not employees.
VARICELLA CASE IDENTIFIED		
1.		Immediately place the patient in a single cell for contact and airborne precaution. Ensure the patient is isolated in a single room until lab results return and until lesions are crusted, typically 4-7 days after onset of rash in immunocompetent people.
2.		Notify the Chief Nurse Executive (CNE) and the Chief Medical Executive (CME) of the varicella case and request a physician order for immediate contact precaution.
3.		A physician initiates communication of needed contact precautions from health care staff to custody. Ensure that an MCC reflects a temporary medical hold for those who are symptomatic.
4.		All outbreak investigations will require a coordinated, multi-disciplinary team to respond to the outbreak. This team should include the following: CME, CNE, PHN, ICN, EHP, Environmental Services Manager, laboratory services if needed, and custody partners including AW or designee, AW HC, C&PR and other key custody staff.
5.		Forms needed by a PHN for a contact investigation can be found at: • Varicella Line List. This list should be updated daily and posted to the SharePoint
6.		Interview varicella suspect patient as soon as possible and investigate the patient's health record for pertinent information. Provide education on signs, symptoms, what to expect, and when to notify health care providers of any changes.
7.		Laboratory specimens should be sent as quickly as possible while patients are still symptomatic. Please see page 5 of the care guide that includes the following: • Varicella Zoster Virus DNA, Qual, PCR (by swabbing lesion or a piece of scab)
8.		If a patient is hospitalized in a community setting, communicate with the treating physician and Utilization Management (UM) nurse: • Contact the UM nurse to request ongoing communication in order to remain informed of in-patient progress and diagnostic study results.
9.		Notify HQ NCPR representative for the institution and submit a Public Health Outbreak Response System (PORS) to CCHCS. The PORS is due within 24 hours of learning a single case of suspected varicella or a confirmed varicella case.

Varicella (Chickenpox) Contact Investigation
Public Health Nurse Checklist
Public Health Branch Warmline: (916) 691-9901

POTENTIAL EXPOSURE PERIOD & IDENTIFY CONTACTS WITH SIGNIFICANT EXPOSURE		
10.		Exposure period should be considered to start 48 hours prior to the index patient's rash onset and end when the index patient is isolated.
11.		The index patient should be interviewed to identify contacts with significant exposure. Perform a patient chart review, collect, and record all pertinent information on initial onset of acute varicella symptoms and/or signs.
12.		List those incarcerated people closely exposed by cohort (e.g., cellies, others in the housing unit, co-workers, etc.). In addition, the Strategic Offender management System (SOMS) should be reviewed to identify any movement inside and outside the cell and/or facility.
13.		Close attention should be paid to potential contacts in classrooms, clinics, or workspaces and other activities by reviewing the Patient Contact Tracing quality management tool.
QUARANTINE PERIOD FOR CONTACTS		
14.		Exposed incarcerated contacts who are non-immune and with no documented history of 2 doses of varicella vaccine require quarantine. Additional immunization information can be found at the California Immunization Registry (CAIR).
15.		Asymptomatic contacts with no history of varicella vaccination and do not have immunity, should be placed in quarantine.
16.		Educate contacts on signs/symptoms of chickenpox, when to seek health care, and what quarantine will entail and timeline.
17.		Non-immune should remain quarantined during the entire quarantine period.
18.		**Quarantined Period:** The timing of quarantine is based on when contacts can be expected to develop disease. Please see Appendix C Varicella Contact Investigation Timeline Calculator. • If any contacts develop symptoms, they should be placed in isolation and treated the same as index case. • Release from medical hold for exposed, as appropriate, by updating the MCC.
19.		Notify pharmacy and prepare for vaccination or other post-exposure prophylaxis for non-immune contact.
20.		Offer **Post-Exposure Prophylaxis** to Patients Exposed: • Ideally, varicella vaccine should be administered to non-immune, exposed contacts within 3 days of exposure, and ordinarily no more than 5 days after varicella exposure. • Vaccine is still indicated for susceptible (non-immune) persons after this window period as it can interrupt transmission during an ongoing outbreak even if given more than 5 days after initial exposure. • Varicella vaccine is a live vaccine and should not be administered to pregnant patients or HIV-infected persons with CD4 <200 mg/dL or other immunosuppressed persons. In that instance, varicella immune globulin (VariZIG®) may be used. It should be administered as soon as possible and within 10 days of first exposure to: ➢ Immunocompromised persons without evidence of varicella immunity (can be identified by the patient risk profile). ➢ Pregnant patients without evidence of varicella immunity.

Varicella (Chickenpox) Contact Investigation
Public Health Nurse Checklist

Public Health Branch Warmline: (916) 691-9901

QUARANTINE AND CLINICAL MONITORING OF CONTACTS		
21.		All contacts should undergo daily surveillance to assess for signs and symptoms. Utilize the Varicella PowerForm and if any develop signs and symptoms, they should be isolated, tested, and placed on the line list.
22.		Contact should be placed in Medical Hold and should not be transferred out of the institution or to a different housing unit.
23.		Restrictions and Privileges While on Quarantine: • Undergo daily surveillance for symptoms. • All contacts in quarantined unit(s) should continue to have yard privileges separate from those not on quarantine. • Restrict them from inter-mingling with non-exposed individuals in yards, classrooms, clinics, schools, work, dining halls, and visiting. • Arrange for quarantined individuals to be fed together in a chow hall in a group by themselves. If this is not possible, feed them in their cells or housing units until they come off the quarantine list. • Non-quarantined incarcerated persons should generally not be admitted to the housing unit after quarantine has been discontinued.
ENVIRONMENTAL INFECTION CONTROL		
24.		**Cleaning:** The isolation room should be terminally cleaned with proper disinfectants by staff with the proper personal protective equipment (PPE).
25.		**Personal Protective Equipment:** Health care providers caring for patients, porters and other staff in contact with ill patients or responsible for cleaning should wear appropriate PPE.

Appendix E: Sample Memorandum to Staff Regarding Chickenpox

NOTE: This is for example purposes only. Institutions should modify based on local operating procedures

CALIFORNIA DEPARTMENT of CORRECTIONS AND REHABILITATION

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:	
To:	All Staff
From:	X, Warden X, Chief Medical Executive X, Chief Executive Officer X, Health Care Captain or Employee Health
Subject:	**VARICELLA OUTBREAK (CHICKENPOX)**

This is to inform you that on (date), a person in this (housing unit) was diagnosed with {suspected} varicella (chickenpox). Persons who may have been exposed may be at risk of developing chickenpox if they do not have prior immunity. Persons develop immunity if they have had chickenpox in the past, or if they have received two doses of vaccine.

Chickenpox in adults, while not as mild as it is in children, is rarely serious, and usually resolves over time. The infection may cause increased complications in adults who are not immune to the virus. Some people are at higher risk for more severe diseases, including people who are pregnant (or those who may become pregnant within a month of exposure to an infected person). Also, people with leukemia, lymphoma, or HIV disease, or those being treated with radiation, chemotherapy, or high dose steroids or other immune suppressing medications, are at higher risk for more severe disease.

If you know you have been in contact with someone with confirmed chickenpox, inform your supervisor. Arrangements will be made to determine if you are susceptible to varicella infection, and whether you require vaccination or other intervention. If you develop signs of chickenpox – low grade fever, flu-like feeling accompanied by clusters of red spots that quickly turn into blisters and then scabs that itch a lot - do not come to work and infect others. Follow up with your physician.

Chickenpox is vaccine preventable.

The administration takes a proactive role in assuring all appropriate precautions are taken and clear communication occurs. We will continue to provide all staff with any further information or developments regarding this matter.

Appendix F: Sample Memorandum to Incarcerated Persons Regarding Chickenpox

NOTE: This is for example purposes only. Institutions should modify based on local operating procedures.

MEMORANDUM

Date: X

To: Incarcerated Persons (In Housing Unit X)

From:

Warden Chief Medical Executive

Subject: **CHICKENPOX ALERT**

On (date)_____, a person in (location), was diagnosed with chickenpox. Chickenpox is a rash illness that is caused by a virus. The rash is very itchy, and people may also have fever.

Most adults with chickenpox will need to be treated with medication called antivirals. People who are pregnant or people who have problems with their immune system can get very sick with chickenpox.

If you were housed in _____, between date and date, you may have been exposed to chickenpox. If you have never had chickenpox in the past or never had a chickenpox vaccine you will be placed in quarantine. Ask your provider about the chickenpox vaccine and if you can get it.

If you start having symptoms, please notify someone right away. Try this: Please notify someone right away if you are having symptoms such as fever, headache, tiredness, no appetite, itchy rash on your face, chest, back and entire body.

Appendix G: Sample Memorandum to Staff Regarding Shingles

NOTE: This is for example purposes only. Institutions should modify based on local operating procedures

CALIFORNIA DEPARTMENT of CORRECTIONS AND REHABILITATION

CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

MEMORANDUM

Date:

To: All Staff

From:

X, Chief Medical Executive or Employee Health

Subject: **RECENT SHINGLES CASE IN _____ UNIT**

On ___(date)_____, a case of shingles (also called herpes zoster) was diagnosed in an individual who resided (or worked) at ____(location)_____. Shingles is a painful skin rash caused by the varicella zoster virus (VZV). VZV is the same virus that causes chickenpox. After a person recovers from chickenpox, the virus stays in the body and usually does not cause any future problems. However, the virus can reappear years later, causing shingles.

Shingles cannot be passed from one person to another. However, if you have never had chickenpox, and if you are exposed to the virus from someone with shingles, you can get chickenpox. The virus is usually spread through direct contact with the rash lesions. It is usually not spread through sneezing, coughing or casual contact. A person with shingles can spread the disease when the rash is in the blister-phase. A person is not infectious before blisters appear or after the blisters completely scab over.

If you have not had chickenpox before -- or are not sure -- and never had chickenpox vaccine, or if you are pregnant -- and you believe you were directly exposed to this recent case of shingles, please notify your supervisor and Return To Work Coordinator immediately. We will make arrangements for you to be assessed by an outside health care provider if necessary. If you develop or experience a questionable skin rash like chicken pox, please stay at home until all lesions are scabbed over and notify your supervisor.

There are shingles and chickenpox vaccines available which you may be eligible for, ask your provider for more information.

Appendix H: Sample Memorandum to Incarcerated Persons Regarding Shingles

NOTE: This is for example purposes only. Institutions should modify based on local operating procedures.

MEMORANDUM

Date: X

To: Incarcerated Persons (In Housing Unit X)

From:

Warden Chief Medical Executive

Subject: **RECENT SHINGLES CASE IN _____ UNIT**

On ___(date)_____, someone with shingles spent time in (location). Shingles is a painful rash caused by the chickenpox virus. This virus is called varicella zoster virus (VZV). You cannot get shingles from someone else. But if someone who has never had chickenpox or had a chickenpox vaccine in the past touches the shingles rash, they could get chickenpox.

Anyone who had chickenpox in the past can get shingles but usually it happens when people are 50 years old or older. People who have medical problems with their immune system are more likely to get shingles.

If you have not had chickenpox before -- or are not sure -- and have never had the chickenpox vaccine, or if you are pregnant and you believe you were exposed to this recent case of shingles, please notify your custody officer or clinic nurse as soon as possible.

People who have never had chickenpox or the chickenpox vaccine will be quarantined to make sure they don't develop chickenpox. Quarantine will end (Date).

The chickenpox vaccine and shingles vaccine are available within CCHCS. Ask your provider for more information.

PATIENT EDUCATION/SELF-MANAGEMENT

CARING FOR YOURSELF WITH CHICKENPOX OR SHINGLES

- Take the medications that your doctor has prescribed.
- Do NOT scratch! Scratching can make it harder for the sores to heal, lead to scarring, and increase the risk that sores will become infected. If itching is particularly severe, ask your doctor for medication.
- Take showers as often as possible – as permitted by your custody officer. Cool showers can help relieve itching. Shower after all others in your housing unit are done showering.
- Apply lotion. Lotions like calamine lotion or a similar agent applied to your rash may help relieve the itching.
- For shingles, keep lesions covered with a loose bandage that can soak up any possible "weeping" of blisters until scabbed over. Dispose of bandages in a red plastic biohazard bag. Inform custody staff or porters if you do not have these bags available.
- Rest. Getting plenty of rest is helpful in getting over any infections.
- Eat a bland diet, if necessary. If sores or blisters develop in your mouth, switch to a diet of soft, bland foods. Spicy, acidic, or hard crunchy foods can irritate the mouth.
- Treat a fever. Fever can be reduced with acetaminophen (Tylenol®): and drink plenty of fluids.
- You will likely be confined to a special hospital bed or private quarters because of chicken pox or shingles, but it should last only about 5 to 7 days or until your lesions are crusted over. At that point, you are no longer infectious to others. Isolation is essential for you, and all concerned to protect everyone in the prison community from getting chicken pox, which can be a potentially serious illness. A nurse will assess you every day to make sure that you are improving and remain healthy while you recover from chickenpox or shingles.

Reference: Chickenpox (Varicella) Prevention and Treatment | CDC

VARICELLA
(CHICKENPOX)

PATIENT EDUCATION

What is varicella (chickenpox)?

Chickenpox is a virus that causes an itchy rash and fever. The rash has fluid-filled blisters that turn into scabs as you get better.

Chickenpox usually lasts 4-7 days. It spreads from person to person. People with weak immune systems or who are pregnant can get very sick. It can also cause birth defects.

What are the symptoms of chickenpox?

Fever

Headache

Tiredness

Loss of appetite

Itchy rash on face, chest and back, entire body

Even if you have a few of these symptoms, you could have chickenpox.

Tell your health care provider if you have these symptoms.

Who is at risk for chickenpox?

Anyone who has never had chickenpox or never had the vaccine.

Varicella (chickenpox) in an Unvaccinated Person

Source: Centers for Disease Control and Prevention

How can I stop chickenpox from spreading?

- Stay away from others while you are sick. You will be isolated until your rash heals.
- Get the vaccine if you have never had chickenpox or the vaccine before.

How to prevent chickenpox?

- The best way to avoid chickenpox is to get the chickenpox vaccine.
- Adults should get the vaccine if they never had chickenpox or the vaccine before.

What if I am exposed to chickenpox?

- If you never had chickenpox or the chickenpox vaccine, you will be placed in quarantine.
- You may be given medicine to help protect you from getting sick.
- Nurses will check on you while you are in quarantine.
- If you develop a rash or feel sick (fever, body aches), tell your provider.

HERPES ZOSTER
(SHINGLES)
PATIENT EDUCATION

What is herpes zoster (shingles)?

Shingles is a painful rash caused by the same virus as chickenpox.

It is most common in people over 50 years old. You cannot catch shingles from someone who has it. However, ***if you have never had chickenpox or the vaccine, you can get chickenpox from someone with shingles.***

What are the symptoms of shingles?

Fever | **Headache** | **Chills** | **Burning, tingling, or pain on your skin**

When the rash appears, it may look like pimples or blisters in one area of your body. The pain can feel like burning or shooting pain. Pain may last longer than the rash.

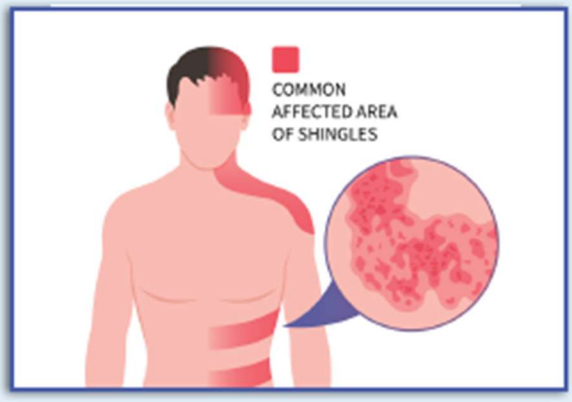
Tell your health care provider if you have these symptoms.

What is the treatment for shingles?

- Your provider may give you medicine for pain.
- You may be given antiviral medicine to help you heal faster.
- Keep your rash clean and try not to scratch.
- You will be isolated until your rash dries and crusts over, which may mean a change in housing.

Who is at risk for shingles?

- Anyone who has had chickenpox or the chickenpox vaccine can get shingles.
- The risk is higher for people over 50 years old.



How do I keep from getting shingles?

- If you are 50 or older you should get the shingles vaccine.
- People who are pregnant and have never had chickenpox or the vaccine should stay away from people with shingles. They should talk to their provider about protection with the chickenpox vaccine.

What if I am exposed to shingles?

- If you never had chickenpox or the chickenpox vaccine, you will be placed in quarantine.
- You may be given medicine to help protect you from getting sick.
- Nurses will check on you while you are in quarantine.
- If you develop a rash or feel sick (fever, body aches), tell your provider.

EDUCACIÓN PARA EL PACIENTE/CONTROL PERSONAL DEL CASO

CUIDARSE CON VARICELA O HERPES ZÓSTER

- Tome los medicamentos que le haya recetado su médico.
- ¡NO rasque! Rascarse puede dificultar la curación de las llagas, provocar cicatrices y aumentar el riesgo de que las llagas se infecten. Si la picazón es particularmente severa, pídale a su médico medicamentos.
- Dúchese con la mayor frecuencia posible, según lo permita su oficial de custodia. Las duchas frías pueden ayudar a aliviar la picazón. Dúchese después de que todos los demás en su unidad de vivienda hayan terminado de ducharse.
- Aplica loción. Las lociones como la loción de calamina o un agente similar aplicado a la erupción pueden ayudar a aliviar la picazón.
- Para el herpes zóster, mantenga las lesiones cubiertas con un vendaje suelto que pueda absorber cualquier posible "supuración" de ampollas hasta que se formen costras. Deseche los vendajes en una bolsa de plástico roja de riesgo biológico. Informe al personal de custodia o a los porteadores si no tiene estas bolsas disponibles.
- Descansar. Descansar lo suficiente es útil para superar cualquier infección.
- Coma una dieta blanda, si es necesario. Si se desarrollan llagas o ampollas en la boca, cambie a una dieta de alimentos blandos y blandos. Los alimentos picantes, ácidos o crujientes duros pueden irritar la boca.
- Trata la fiebre. La fiebre se puede reducir con acetaminofén (Tylenol®): y beber muchos líquidos.
- Es probable que esté confinado a una cama especial de hospital o a un alojamiento privado debido a la varicela o al herpes zóster, pero debería durar solo entre 5 y 7 días o hasta que las lesiones formen costras. En ese momento, ya no eres infeccioso para los demás. El aislamiento es esencial para usted y para todos los interesados para proteger a todos en la comunidad carcelaria de contraer varicela, que puede ser una enfermedad potencialmente grave. Una enfermera lo evaluará todos los días para asegurarse de que esté mejorando y se mantenga saludable mientras se recupera de la varicela o el herpes zóster.

Referencia: Chickenpox (Varicella) Prevention and Treatment | CDC

Cartel de la varicela 5-9-25 Español

EDUCACIÓN DEL PACIENTE PARA

LA VARICELA

¿Qué es la varicela?

La varicela es causada por un virus que causa una erupción cutánea con picazón y fiebre. La erupción tiene ampollas llenas de líquido que se convierten en costras a medida que mejora.

La varicela suele durar de 4 a 7 días. Se transmite de persona a persona. Las personas con sistemas inmunitarios débiles o embarazadas pueden enfermarse gravemente. También puede causar defectos congénitos.

¿CUÁLES SON LOS SÍNTOMAS DE LA VARICELA?

Fiebre | **Jaqueca** | **Cansancio** | **Pérdida de apetito** | **Erupción cutánea con picazón en cara, pecho y espalda, cuerpo entero**

Incluso si solo tiene algunos de estos síntomas, podría tener varicela.
Dígale a su proveedor de atención médica.

¿Quién está en riesgo de contraer varicela?

Cualquier persona que nunca haya tenido varicela o que nunca se haya vacunado.

Varicela en una persona no vacunada

Fuente: Centros para el Control y la Prevención de Enfermedades

¿Cómo puedo evitar que la varicela se propague?

- Manténgase alejado de los demás mientras esté enfermo. Estará aislado hasta que el sarpullido sane.
- Vacúnese si nunca ha tenido varicela o la vacuna.

¿Cómo prevenir la varicela?

- La mejor manera de evitar la varicela es vacunarse contra la varicela.
- Los adultos deben recibir la vacuna si nunca tuvieron varicela o la vacuna.

¿Qué pasa si estoy expuesto a la varicela?

- Si nunca ha tenido varicela ni se ha vacunado, se le pondrá en cuarentena.
- Es posible que le administren medicamentos para ayudar a protegerlo de enfermarse.
- Las enfermeras te revisaran mientras esté en cuarentena.
- Si se siente enfermo (sarpullido, fiebre, dolores corporales), dígaselo a su proveedor de atención médica.

Cartel de herpes zóster 5-9-25 Español

EDUCATIÓN PARA PACIENTES SOBRE EL

HERPES ZÓSTER
(CULEBRILLA)

¿Qué es el herpes zóster (culebrilla)?

El herpes zóster es una erupción dolorosa causada por el mismo virus que la varicela.

Es más común en personas mayores de 50 años. No puede contraer herpes zóster de alguien que lo tenga. ***Si nunca ha tenido varicela o la vacuna, puede contraer la varicela de alguien con herpes zóster.***

¿Cuáles son los síntomas del herpes zóster?

Antes de que aparezca la erupción, es posible que tenga:

Fiebre

Dolor de cabeza

Escalofríos

Ardor, hormigueo o dolor en la piel

Cuando aparece la erupción, puede verse como granos o ampollas en un área de su cuerpo. El dolor puede sentirse como ardor o punzante. El dolor puede durar más que la erupción.

Dígale a su proveedor de atención médica si tiene estos síntomas.

¿Cuál es el tratamiento para el herpes zóster?

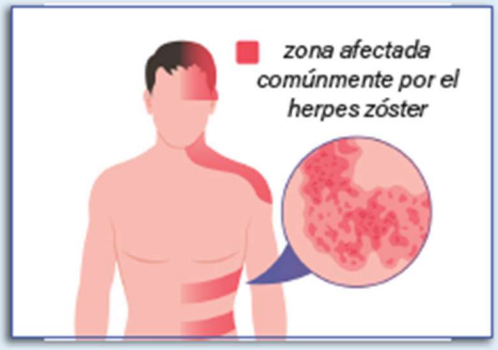
- Su proveedor puede darle medicamentos para el dolor.
- Es posible que le administren medicamentos antivirales para ayudarlo a sanar más rápido.
- Mantenga su erupción limpia y trate de no rascarse.
- Estará aislado hasta que la erupción se seque y se formen costras, lo que puede significar un cambio en la vivienda.

¿Quién está en reisgo de contraer herpes zóster?

- Cualquier persona que haya tenido varicela o la vacuna contra la varicela puede contraer herpes zóster.
- El riesgo es mayor para las personas mayores de 50 años.

¿Cómo evito contraer herpes zóster?

- Si tiene 50 años o más, debe recibir la vacuna contra el herpes zóster.
- Las personas que están embarazadas y nunca han tenido varicela o la vacuna deben permanecer vacuna contra la varicela.



¿Qué pasa si estoy expuesto al herpes zóster?

- Si nunca tuvo varicela o la vacuna contra la varicela, se le pondrá en cuarentena.
- Es posible que le administren medicamentos para ayudar a protegerlo de la infección.
- La cuarentena ayuda a prevenir la propagación de la varicela.
- El personal de enfermería lo observará para detectar síntomas mientras esté en cuarentena.
- Si desarrolla una erupción cutánea o se siente enfermo (fiebre, dolores corporales), informe a su proveedor.