

COMMUNICABLE DISEASE • HIGH-YIELD COMPENDIUM

The Contagious Six.

A pediatric nurse's field guide to varicella, measles, rotavirus, norovirus, roseola & HPV — with clinical judgment at every bedside.

 Varicella AIRBORNE • CONTACT	 Measles AIRBORNE	 Rotavirus CONTACT	 Norovirus CONTACT	 Roseola STANDARD	 HPV STANDARD
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Isolation Precautions — at a glance

AIR + CONTACT	Varicella (chickenpox) — negative-pressure room, N95, gown & gloves until all lesions crusted. Pregnant & non-immune staff shall not enter.
AIRBORNE	Measles (rubeola) — negative-pressure AIIR, N95 for all entering; isolate until 4 days after rash onset.
CONTACT	Rotavirus & Norovirus — private room or cohort, gown & gloves, dedicated equipment. Soap & water — alcohol gel does <u>not</u> inactivate these viruses.
STANDARD	Roseola & HPV — routine precautions; hand hygiene, PPE per task.

PPE & room quick-key

N95 — fit-tested respirator for airborne pathogens.	AIIR — airborne infection isolation room (neg. pressure, 6–12 ACH).
Surgical mask — droplet only, ≥6-ft radius.	Gown + gloves — contact transmission; doff before exit.
Soap & water — non-enveloped viruses (noro / rota).	Alcohol gel — enveloped only; ineffective against noro/rota/C-diff.

Live-attenuated vaccines (MMR, varicella, rotavirus) are contraindicated in immunocompromised & pregnant patients.

01 → 06

The **Next-Generation NCLEX** tests clinical judgment in six iterative steps: **Recognize cues • Analyze cues • Prioritize hypotheses • Generate solutions • Take action • Evaluate outcomes.** Every page that follows is organized to move you through these six lenses — from rash pattern to isolation order to vaccine counseling.

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PEDIATRIC COMMUNICABLE DISEASE • VOLUME I

01

Varicella — Chickenpox.

Varicella-zoster virus (VZV · HHV-3) · Pruritic vesicular exanthem of childhood.

PRECAUTIONS

Airborne + Contact

 <i>lesions in all stages</i>	PATHOGEN Varicella-zoster virus (HHV-3)	INCUBATION 10–21 days	CONTAGIOUS 1–2 d pre-rash → all crusted	VACCINE Varicella (live) · 12–15 mo & 4–6 yr
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• Clinical Manifestations

- › **Prodrome (24–48 hr):** low-grade fever, malaise, anorexia, mild headache.
- › **Classic rash:** *macule → papule → vesicle → pustule → crust*; lesions appear in successive crops — **all stages present simultaneously**.
- › **"Dewdrop on a rose petal"** vesicle on erythematous base — pathognomonic.
- › Intensely **pruritic**; begins on trunk & scalp, spreads centripetally to face & extremities.
- › May involve mucous membranes (mouth, conjunctiva, genitals).

• Transmission & Diagnostics

- › **Airborne** respiratory droplets + direct **contact** with vesicle fluid.
- › Extremely contagious — secondary attack rate in household > 85%.
- › Clinical diagnosis; confirm with **PCR of vesicle fluid** (gold standard), Tzanck smear, or VZV serology.
- › Reactivation as **shingles** (herpes zoster) along dermatome later in life.

• Nursing Priorities & Management

- › **Isolation:** Airborne + Contact in negative-pressure room until **all lesions crusted**.
- › **Pruritus control:** colloidal **oatmeal baths**, calamine lotion, cool compresses, diphenhydramine; trim fingernails, mittens for infants.
- › **Antipyretic:** acetaminophen only. **✗ NEVER aspirin** (Reye syndrome risk).
- › **Antiviral:** acyclovir for immunocompromised, neonates, adolescents, or severe disease — start within 24 hr of rash.
- › VariZIG (VZ immune globulin) for exposed high-risk contacts.

• Complications to Recognize

- › **Secondary bacterial skin infection** (Staph/Strep) — most common complication; watch for spreading erythema, warmth, purulence.
- › **Varicella pneumonia** — adolescents & immunocompromised.
- › **Encephalitis / cerebellar ataxia** — headache, altered mentation, wide-based gait.
- › **Reye syndrome** — if aspirin administered.
- › **Congenital varicella syndrome** if maternal infection 8–20 wk gestation.

*A 5-year-old with 60 crusted and 15 fluid-filled lesions presents on hospital day 4.
Mother asks when siblings may visit and when the child can return to school.*

01

Recognize:
lesions in
mixed stages
→ still
contagious.

02

Analyze:
contagious
until **ALL**
crusted.

03

Prioritize:
maintain
airborne +
contact
isolation.

04

Generate: screen
visitors for
immunity/pregnancy.

05

Act: return to
school only
when **all**
crusted.

06

Evaluate:
inspect lesions
daily;
document
crust %.

MNEMONIC

DEWDROPS

Dewdrop vesicles on a rose-petal base ·
lesions **D**ifferent stages · **E**xremely
contagious · **W**atch for Reye (no ASA) · **D**ry
with calamine · **R**ash on trunk first · **O**atmeal
bath · **P**rivate room, neg-pressure · **S**hingles
later.

02

PEDIATRIC COMMUNICABLE DISEASE • VOLUME II

Measles — *Rubeola*.

Measles morbillivirus (Paramyxoviridae) • One of the most contagious human pathogens known.

PRECAUTIONS

Airborne



Koplik spots • rash begins at hairline

PATHOGEN

Measles morbillivirus • ssRNA

INCUBATION

8–12 days

CONTAGIOUS

4 d before → 4 d after rash

VACCINE

MMR (live) • 12–15 mo & 4–6 yr

• Clinical Manifestations

- › **Prodrome — the 3 C's: Cough, Coryza, Conjunctivitis** + high fever (104°F+) & photophobia.
- › **Koplik spots** — 1–3 mm bluish-white papules on erythematous buccal mucosa opposite 2nd molars; **pathognomonic**, appear 1–2 days before rash.
- › **Exanthem**: red-brown maculopapular rash begins at the **hairline/face** and descends **cephalocaudally** to trunk & extremities over 3 days.
- › Rash **fades in order of appearance** with brownish desquamation.
- › Systemic: malaise, anorexia, lymphadenopathy.

• Transmission & Diagnostics

- › **Airborne** — droplets linger up to 2 hr after patient leaves the room.
- › $R_0 = 12–18$ (compare influenza $R_0 = 1–2$).
- › Diagnosis: **measles IgM** serology + viral PCR of nasopharyngeal/throat/urine.
- › **Reportable to public health** — notify within 24 hr.

• Nursing Priorities & Management

- › **Isolation**: AIR (neg-pressure, N95) until **4 days after rash onset**.
- › **Vitamin A** — single WHO-recommended intervention proven to reduce measles mortality, especially < 2 yr.
- › Supportive: antipyretics (no aspirin), hydration, humidified air for cough.
- › **Dim lights**, limit reading/screens for photophobia.
- › Screen all staff/visitors for MMR immunity — non-immune must not enter.
- › Post-exposure prophylaxis: MMR within 72 hr OR IG within 6 days of exposure.

• Complications to Recognize

- › **Otitis media** — most common.
- › **Pneumonia** — leading cause of measles-related death in children.
- › **Acute encephalitis** (1 in 1,000) — seizure, coma, altered mental status.
- › **SSPE** (subacute sclerosing panencephalitis) — fatal neurodegenerative disease emerging 7–10 yr after infection.
- › Diarrhea, dehydration, corneal ulceration.

A 4-year-old unvaccinated child presents to ED with 103°F fever, red watery eyes, barking cough, and "grains of salt" inside the cheeks. Triage nurse assigns a standard exam room.

01 Recognize: Koplik spots + 3 C's → measles suspected.	02 Analyze: airborne pathogen loose in waiting area.	03 Prioritize: immediate source control.	04 Generate: AllR, mask child, N95 staff.	05 Act: move child, notify public health, draw IgM.	06 Evaluate: trace & offer PEP to exposed non-immune.
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MNEMONIC

3 C's + K

Cough · **C**oryza · **C**onjunctivitis + **K**oplik spots.
Rash Cephalocaudal (face → feet). Vitamin A reduces mortality. Airborne until 4 days after rash.

03

PEDIATRIC COMMUNICABLE DISEASE • VOLUME III

Rotavirus — *the wheel*

Rotavirus A (Reoviridae · dsRNA) · Leading global cause of severe infant/toddler gastroenteritis.

PRECAUTIONS

Contact



rota = wheel · watery loss

PATHOGEN

Rotavirus A · non-enveloped dsRNA

INCUBATION

1–3 days

DURATION

3–8 days of symptoms

VACCINE

RV1/RV5 oral, live · 2 & 4 mo (± 6 mo)

• Clinical Manifestations

- › **Abrupt** onset vomiting (1–3 days) followed by profuse **watery** diarrhea (often 10–20 stools/day).
- › Low-grade fever, anorexia, abdominal cramping.
- › Peak severity in infants 6–24 months.
- › **Dehydration cues:** sunken fontanel, dry mucous membranes, tachycardia, decreased tearing, cap refill > 2 s, ↓ urine output, irritability → lethargy.

• Transmission & Diagnostics

- › **Fecal-oral** route; virus survives on hands/surfaces for hours–days.
- › **Non-enveloped** — alcohol sanitizer ineffective; use **soap & water** & bleach for surfaces.
- › Diagnosis: **stool antigen EIA** or PCR multiplex GI panel.
- › Consider electrolytes, BUN/Cr, glucose if dehydration suspected — watch for **metabolic acidosis** & **hypokalemia**.

• Nursing Priorities & Management

- › **Contact precautions;** private room or cohort with other rotavirus patients.
- › **Oral rehydration** (Pedialyte/WHO-ORS) — small, frequent sips: 5 mL q 1–5 min; 50–100 mL/kg over 4 hr for mild-moderate dehydration.
- › Escalate to **IV isotonic fluids** (20 mL/kg bolus NS or LR) for severe dehydration or persistent vomiting.
- › **Resume age-appropriate diet** ASAP once rehydrated — breast milk, formula, complex carbs. ❌ Avoid prolonged clear liquids, BRAT (too low in protein/energy), plain water in infants.
- › Strict **I&O**, daily weights, diaper counts; minimum urine output **1 mL/kg/hr** in infants.
- › Antiemetics/anti-diarrheals **not routine** in peds.

• Vaccine Pearls & Safety

- › **RV1 (Rotarix)** 2-dose series · **RV5 (RotaTeq)** 3-dose series — both oral, live-attenuated.
- › First dose **by 14 wk 6 d**; series complete **by 8 mo 0 d** (do not initiate after 15 wk).
- › **Contraindications:** hx of intussusception, SCID.
- › Watch for **intussusception** post-vaccine: inconsolable crying, drawing knees up, **currant-jelly stools**, sausage-shaped abdominal mass.

A 9-month-old has had watery diarrhea & vomiting x 2 days. HR 170, cap refill 3 s, sunken fontanel, last wet diaper 8 hr ago, weight down 8% from baseline.

01

Recognize: severe dehydration (>9% loss, ↓perfusion).

02

Analyze: at risk for hypovolemic shock, acidosis.

03

Prioritize: restore circulating volume.

04

Generate: IV NS 20 mL/kg bolus, labs, contact iso.

05

Act: place IV, bolus, reassess HR/cap refill/LOC.

06

Evaluate: goal UOP ≥1 mL/kg/hr, HR ↓, moist membranes.

MNEMONIC

WHEEL

Watery diarrhea • Hydration first •
Electrolytes (K⁺, bicarb) • Early oral vaccine •
Look for intussusception. Rota = wheel; fluids keep it turning.

PEDIATRIC COMMUNICABLE DISEASE • VOLUME IV

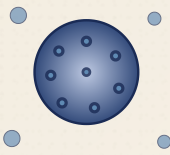
04

Norovirus — *the outbreak.*

Norovirus (Caliciviridae) · "Cruise ship / school cafeteria" virus · leading cause of acute gastroenteritis across ages.

PRECAUTIONS

Contact

 rapid explosive outbreak	PATHOGEN Norovirus · non-enveloped ssRNA	INCUBATION 12–48 hours	DURATION 1–3 days (short, intense)	VACCINE None available · prevention = hygiene
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• Clinical Manifestations

- › **Sudden-onset** projectile vomiting + watery non-bloody diarrhea.
- › Abdominal cramps, nausea, low-grade fever, myalgia, headache.
- › Symptoms **self-limiting in 24–72 hr** (shorter than rotavirus).
- › Dehydration risk highest in infants, toddlers, elderly, immunocompromised.

• Transmission & Outbreak Control

- › **Fecal-oral** — contaminated food (especially shellfish, leafy greens), water, surfaces, person-to-person.
- › As few as **18 viral particles** cause infection — among the most infectious human pathogens.
- › Shed in stool up to **2 weeks post-recovery**; aerosolized from vomit.
- › **Alcohol sanitizer ineffective** (non-enveloped) — **soap & water, 20-s friction**.
- › **Bleach 1:10** (5,000 ppm) on hard surfaces for environmental disinfection.

• Nursing Priorities & Management

- › **Contact precautions** for duration of illness; cohort during outbreaks; single-patient equipment.
- › Treatment is **supportive**: oral rehydration therapy; IV fluids for severe dehydration or intractable vomiting.
- › Monitor hydration status: weight, mucous membranes, cap refill, UOP, fontanel in infants.
- › **Exclude ill food-handlers, daycare workers, healthcare staff for ≥48 hr after symptoms resolve.**
- › Hand hygiene with soap & water **before/after every patient contact**.
- › Immediately clean vomit/diarrhea with PPE + bleach solution; bag & remove soiled linens carefully.

• High-Yield Differentiators

- › **Noro vs Rota**: Noro = rapid onset, brief (1–3 d), all ages, **no vaccine**. Rota = younger infants, longer (3–8 d), oral vaccine available.
- › Noro does **not** cause bloody stool — if bloody, suspect Shigella/E. coli/Salmonella/IBD.
- › Reinfection common — **immunity is strain-specific & short-lived**.
- › Outbreaks common: cruise ships, schools, LTC, daycare, catered events.

A 7-year-old returns from a weekend camp where 40 children developed vomiting & diarrhea within 24 hr. She is now on hospital day 1 with mild dehydration. A nurse reaches for the alcohol gel at the doorway.

01

Recognize: outbreak pattern suggests norovirus.

02

Analyze: non-enveloped — alcohol gel is ineffective.

03

Prioritize: break fecal-oral chain, rehydrate.

04

Generate: soap/water, contact iso, ORT, bleach 1:10.

05

Act: wash hands with soap, don gown/gloves, start ORT.

06

Evaluate: no new cases on unit; child rehydrating.

MNEMONIC

FAST

Fast onset (12–48 hr) · **A**ll ages affected ·
Short course (1–3 d) · **T**ransmission fecal-oral. Soap & water — not sanitizer. Exclude 48 hr post-symptoms.

PEDIATRIC COMMUNICABLE DISEASE • VOLUME V

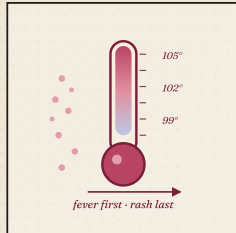
05

Roseola — *Sixth Disease.*

Exanthem subitum • HHV-6 (rarely HHV-7) • Benign febrile illness of infancy (6–24 mo).

PRECAUTIONS

Standard



PATHOGEN

HHV-6 • (occasionally
HHV-7)

AGE GROUP

6–24 months (peak)

FEVER

3–5 d • up to 106°F

VACCINE

None • **supportive
care only**

• Classic Sequence

- › **Phase 1 — High fever** 103–106°F for 3–5 days in an otherwise **well-appearing** infant.
- › **Phase 2 — Defervescence:** fever drops **abruptly**.
- › **Phase 3 — Exanthem:** **rose-pink maculopapular** rash appears on the **trunk first**, then spreads to neck & extremities; often spares face.
- › Rash is **blanching**, non-pruritic, fades in 1–2 days.
- › Often **mild URI** symptoms, nagayama spots (red papules on soft palate/uvula), cervical lymphadenopathy.

• Transmission & Diagnostics

- › **Saliva & respiratory droplets** from asymptomatic adults/older children.
- › Clinical diagnosis — lab testing rarely needed; PCR or serology reserved for atypical or immunocompromised cases.
- › By age 2, **~90% of children are seropositive**.

• Nursing Priorities & Management

- › **Antipyretics:** acetaminophen 10–15 mg/kg q 4–6 hr or ibuprofen (>6 mo) 10 mg/kg q 6–8 hr. **✗ No aspirin.**
- › Tepid sponge bath, light clothing, cool environment. Avoid ice/alcohol baths.
- › **Generous fluids;** monitor for dehydration & adequate UOP.
- › **Seizure precautions** — 10–15% of affected children have a **febrile seizure** during Phase 1.
- › Reassure families: rash means fever is ending; child remains well-appearing.
- › Standard precautions in hospital — no isolation required.

• Febrile Seizure Teaching

- › Most common cause of seizure in 6 mo – 5 yr; usually **simple** (generalized, < 15 min, does not recur within 24 hr).
- › **During seizure:** protect from injury, side-lying position, **do not** restrain, **do not** place anything in mouth, time it.
- › Call EMS if seizure > 5 min, recurs, focal, respiratory distress, cyanosis, persistent altered LOC.
- › Risk ≠ epilepsy; simple febrile seizures do not cause brain damage or long-term deficits.
- › Antipyretics reduce discomfort but **do not** prevent febrile seizures.

A 14-month-old arrives in clinic with 104.2°F fever for 3 days, no rash, no cough, no source on exam. Mother panicking. Later that afternoon, the fever abruptly normalizes and a pink trunk rash emerges.

01

Recognize: high fever, well-appearing, >6 mo old.

02

Analyze: classic roseola — rash follows fever.

03

Prioritize: comfort + seizure safety.

04

Generate: antipyretic, hydration, standard precautions.

05

Act: teach seizure first aid, reassure parents.

06

Evaluate: child afebrile, hydrated, rash fading.

MNEMONIC

FEVER FIRST

High **F**ever (3–5 d) · then **E**xanthem · **V**irus (HHV-6) · **E**xcellent prognosis · **R**isk = febrile seizure. Rash arrives as the fever departs.

PEDIATRIC COMMUNICABLE DISEASE • VOLUME VI

06

HPV — *Human Papillomavirus*.

>100 types · High-risk 16 & 18 cause ~70% of cervical cancer · Low-risk 6 & 11 cause most genital warts.

PRECAUTIONS

Standard



vaccinate before exposure

PATHOGEN

HPV · dsDNA, >100 types

TRANSMISSION

Skin · sexual · vertical (rare)

VACCINE AGE

Routine 11–12 yr (start 9)

SCHEDULE

2-dose <15 yr · 3-dose ≥15 yr

• Clinical Manifestations

- › Most HPV infections are **asymptomatic & self-clearing** within 1–2 years.
- › **Low-risk types 6, 11:** *condyloma acuminata* (genital/anal warts), laryngeal papillomas.
- › **High-risk types 16, 18, 31, 33, 45, 52, 58:** precancerous dysplasia → cervical, vulvar, vaginal, anal, penile, oropharyngeal cancers.
- › **Recurrent respiratory papillomatosis** — rare pediatric complication from vertical transmission at birth; presents with hoarseness, stridor, airway obstruction.
- › Common childhood warts (verruca vulgaris, plantar) are caused by different HPV types — not STI-related.

• Transmission & Screening

- › **Skin-to-skin & mucosal contact** during sexual activity; condoms reduce but don't eliminate risk.
- › Vertical transmission possible during vaginal birth (low risk).
- › **Cervical cancer screening** begins at age 21 regardless of sexual activity or vaccination status — Pap q 3 yr, or Pap + HPV co-testing q 5 yr at 30+.
- › HPV testing is **not** routinely performed in adolescents or males.

• Vaccine — Gardasil 9 (9-valent)

- › **Routine at 11–12 yr;** may begin at age 9; catch-up through age 26; shared decision-making 27–45 yr.
- › **2-dose series** if initiated **before age 15:** 0 & 6–12 mo apart.
- › **3-dose series** if initiated **age 15+** or immunocompromised: 0, 1–2, 6 mo.
- › **Not a live vaccine** — safe for immunocompromised; administer IM (deltoid).
- › **Contraindication:** severe allergy to yeast or prior dose; hold if moderate–severe acute illness.
- › **Pregnancy:** defer vaccination, complete series postpartum; breastfeeding is not a contraindication.

• Nursing Counseling & Adolescent Care

- › **Vaccinate before sexual debut** — maximum efficacy when given before exposure.
- › Recommended for **both females and males** — prevents cancer & reduces community transmission.
- › Expect common side effects: injection-site pain/redness, low-grade fever, syncope — **observe seated 15 min** post-injection (higher syncope rate in adolescents).
- › Reinforce **confidentiality** with adolescents per state law; address parental concerns with evidence on safety & cancer prevention.
- › Pairs well with same-visit Tdap & MenACWY at the 11–12-year adolescent platform visit.

- › Vaccination does **not** eliminate need for continued cervical cancer screening.

N · CLINICAL JUDGMENT

An 11-year-old arrives for a well-child visit. Mother states, "She's not dating — she doesn't need any of that HPV stuff yet." The child is silent but nods toward the vaccine brochure.

01

Recognize:
parental
hesitancy;
missed-
opportunity
risk.

02

Analyze:
efficacy highest
pre-exposure;
2-dose eligible
now.

03

Prioritize:
cancer
prevention,
bundled
adolescent
vaccines.

04

Generate:
"cancer
prevention"
framing, peer-
reviewed data.

05

Act: offer Tdap
+ MenACWY +
HPV; observe 15
min.

06

Evaluate:
schedule 2nd
HPV dose at 6–
12 mo.

MNEMONIC

9 TO 26

Start at **9**, routine at **11–12**, catch-up to **26**. **2**
doses if <15, **3** doses if 15+. **Not** live. Both
sexes. Before debut. Cancer prevention.

MASTER SUMMARY · NGN SYNTHESIS

The Six, *side by side.*

One glance comparison of rash, transmission, timing & vaccine — followed by clinical judgment drills.

DISEASE	PATHOGEN · INCUBATION	HALLMARK FEATURES	ISOLATION	VACCINE & PEARL
● Varicella <i>Chickenpox · HHV-3</i>	VZV · 10–21 d	Pruritic rash · macule → papule → vesicle (dewdrop) → pustule → crust · all stages simultaneously	Airborne + Contact · neg-pressure room · until all crusted	MMRV/Varicella (live) · 12–15 mo & 4–6 yr · no aspirin → Reye
● Measles <i>Rubeola · Paramyxovirus</i>	Measles · 8–12 d	3 C's (cough, coryza, conjunctivitis) + Koplik spots · rash starts at hairline → descends	Airborne · N95, AIIR · until 4 d post-rash · reportable	MMR (live) · 12–15 mo & 4–6 yr · Vitamin A ↓ mortality
● Rotavirus <i>GI · dsRNA</i>	Reovirus · 1–3 d	Severe watery diarrhea + vomiting · fever · dehydration · infants 6–24 mo	Contact · soap & water (alcohol ineffective)	Oral live vaccine · start by 14 wk 6 d · watch for intussusception
● Norovirus <i>GI · Calicivirus</i>	Norovirus · 12–48 hr	Sudden vomiting + diarrhea · outbreaks · short course 1–3 d · all ages	Contact · soap & water , bleach 1:10 · exclude ≥ 48 hr post-sx	No vaccine · hand hygiene & outbreak control are the intervention
● Roseola <i>6th Disease · HHV-6</i>	HHV-6 · 9–10 d	High fever 3–5 d → rash AFTER fever resolves · pink macules on trunk · well-appearing	Standard precautions	No vaccine · watch for febrile seizure · antipyretic, no ASA
● HPV <i>dsDNA · >100 types</i>	HPV · weeks–months	Mostly asymptomatic · genital warts (6,11) · cervical/anal/oropharyngeal cancers (16,18)	Standard precautions	Gardasil 9 (not live) · 9–26 yr · 2 doses <15 , 3 doses ≥15

Rash Sequencing, *the exam's favorite distractor.*

● Varicella <i>macule → papule → vesicle → pustule → crust</i> Key: all stages at once; trunk before face; intensely pruritic; the "dewdrop on rose petal" vesicle.	● Measles <i>Koplik → face/hairline → trunk → extremities</i> Key: rash moves cephalocaudal ; preceded by 3 C's; fades in order of appearance with desquamation.	● Roseola <i>High fever 3–5 d → fever breaks → rash</i> Key: rash on trunk , spares face; appears as fever ends ; child well-appearing; watch for febrile seizure.
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NGN ITEM · BOW-TIE

Prioritize the action

8-month-old, 5 days watery diarrhea, HR 180, sunken fontanel, cap refill 4 s, last void 10 hr ago.

- CONDITION** Severe hypovolemic dehydration (rotavirus likely).
FIRST IV access · 20 mL/kg isotonic bolus (NS/LR).
THEN Reassess HR, cap refill, UOP · contact precautions · electrolytes + stool EIA.

NGN ITEM · HIGHLIGHT

NGN ITEM · DRAG-&-DROP

Match rash to disease

Maculopapular rash starts at the hairline and descends to the feet, preceded by cough, coryza, and conjunctivitis.

- ANSWER** Measles (rubeola) — cephalocaudal + 3 C's + Koplik = pathognomonic.
RATIONALE Varicella = mixed stages trunk-out; roseola rash follows defervescence; rota/noro = no rash.

NGN ITEM · MULTIPLE RESPONSE

Identify correct teaching

At a norovirus outbreak in-service — which staff statement indicates need for further teaching?

INCORRECT "I'll use alcohol gel between every patient."

TEACH Norovirus is **non-enveloped** · alcohol gel ineffective · use **soap & water** + **1:10 bleach** on surfaces.

Select vaccine-eligible children

Which of these clients should receive HPV vaccine today? (SATA)

- ☒ 11-yr-old at well-child visit — **routine**.
- ☒ 13-yr-old male w/ asthma — **both sexes**; chronic illness ≠ contraindication.
- ☒ 18-yr-old unvaccinated — **catch-up** through 26 (3-dose).
- ☒ 15-yr-old w/ moderate acute illness + fever — **defer**.