Health Advisory

JB Pritzker, Governor | Sameer Vohra, MD, JD, MA, Director

Measles Cases Identified amid Increasing Regional Activity

Summary and Action Items

1. Two cases of measles have been identified in Illinois this week: one in an unvaccinated Kane County resident after returning from international travel, and an unrelated case in an unvaccinated resident of Central Illinois.
2. International travel is **high risk** for measles exposure. There are additional specific MMR vaccine recommendations for international travel, including an early MMR dose for travelers 6–11 months. Providers should consider applying these recommendations for those traveling domestically to areas with known measles outbreaks.
3. Measles can spread quickly in schools. School administrators and providers are highly encouraged to maintain organized vaccination records for students **and staff** to minimize disruptions to school operations in the event of a measles introduction.
4. Clinicians are required to **immediately report to public health** any suspect measles cases at the time it is first suspected and prior to clinical testing. See the **IDPH Clinician Measles Mini-Toolkit** for symptom screener, diagnostic, and laboratory considerations.
5. IDPH provides PCR testing for measles at no cost. **Testing at commercial laboratories is discouraged unless specifically requested by public health.**
6. Clinicians and health care facilities should take steps to ensure that their patient populations and staff are up to date on their measles vaccines or have presumptive evidence of immunity to measles in order to expedite decisions on time sensitive post-exposure prophylaxis.

Background

IDPH has identified 6 cases of measles among IL residents in 2026, including 2 this week. On 8/22 IDPH confirmed measles in an unvaccinated Kane County resident who had recently traveled internationally. This patient's contagious period ended on 8/24. On 8/27, IDPH confirmed measles in an unvaccinated Central Illinois resident. IDPH continues to work closely with the local health departments to identify any additional case and exposure locations, as well as to protect and monitor exposed individuals. Known exposure locations are listed below; these and any additional exposure locations identified can be viewed on the IDPH Measles Exposure Locations website.

Exposure Location	Address	Dates/Times of Exposure
Kaneland High School	47W326 Keslinger Rd Maple Park, IL 60151	8/18 from 7:20am to 4:50pm
Next Generation Pediatric Clinic	107 S. McLean Blvd. Suite B South Elgin, IL 60177	8/21 from 12:30pm to 4pm

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These cases occur amid increasing measles activity across the region, including in Southern Iowa, Southwest Wisconsin, and Western Kentucky . National activity remains elevated as well, including a large outbreak in Pennsylvania where two measles-related deaths have been reported in unvaccinated residents—the first measles-related deaths in the U.S. since 2025 and the first in Pennsylvania in 35 years.

International travel is high-risk for measles exposure, and all age-eligible travelers, including infants ages 6–11mo, should be vaccinated at least 2 weeks prior to travel in accordance with specific MMR pre-travel guidance (see below).

Schools

Measles can spread quickly in schools. School administrators and staff should be prepared to respond to a measles exposure in their school.

- Illinois requires all school-aged children to be protected against measles.
- Schools should have readily accessible and organized vaccination records for all students, and should maintain ready awareness of which students are not protected.
- Although school staff are not required to be immunized against measles, IDPH highly recommends that they be protected.
- School administrators are likewise **highly encouraged** to collect and maintain staff vaccination records. In the event of a measles introduction in a school, exposed staff will be required to quarantine until they provide documentation proof of immunity.

Diagnosis

Clinicians and healthcare facilities should be alert for possible measles cases, especially in people who could have traveled to locations with ongoing transmission.

- **If you suspect measles, immediately place the patient in airborne isolation, and notify the following:**
  - Your facility's infection control team or point person for measles response.
  - Your local health department
- Clinicians should review the IDPH Clinician Measles Mini-Toolkit, which includes a testing flowchart, to guide decisions on testing.
- Symptoms typically appear 7–14 days after exposure and begin with fever and respiratory symptoms, followed 3–5 days later by a generalized maculopapular rash that typically starts on the head or hairline and spreads down the body.

Reporting

Clinicians and health care facilities should immediately (no later than within 3 hours) report suspect measles cases to their local health department or to IDPH.

- **Reporting should occur at earliest clinical suspicion; do not wait on laboratory confirmation or rely on laboratory reporting.**
- Delays in reporting might result in avoidable exposures as well as missed prophylaxis options for non-immune close contacts.
- If unable to reach your local health department after-hours, contact IEMA-OHS at 217-782-7860 to reach someone at IDPH.

Testing

IDPH laboratories provide PCR testing of throat or nasopharyngeal swabs for measles at no cost to the patient or provider.

- Suspected measles cases should be tested by PCR at the state lab as testing at commercial laboratories can delay results and subsequent public health responses (see instructions for submission). Swabs should be placed in viral transport media (VTM).
  - **Do not send PCR swabs to commercial labs unless specifically instructed by public health.**
- Serum can be tested by commercial laboratories for measles-specific IgM antibodies, but serology testing alone is insufficient for diagnosis. Diagnostic serology should always be paired with PCR testing.
- Urine PCR testing can also be considered in some cases after consultation with public health, especially if testing occurs >5 days after onset.

Transmission and Infection Control

The measles virus spreads easily through contact with respiratory droplets and via airborne spread. The virus can remain airborne for up to two hours after an infectious person leaves an area. Measles is highly contagious. Up to 90% of susceptible people who have contact with someone with measles will develop measles. Patients are contagious starting four days before through four days after rash onset (with rash onset date being day zero). Anyone with measles should isolate during that time except to seek necessary medical care. If medical care is required, patients should call to notify the facility BEFORE entering and disclose that they have been exposed to measles.

Health care personnel should follow CDC's Interim Guidelines on Measles Infection Control in Healthcare settings when dealing with potential measles cases and determining degree of exposure (Appendix A in the guidance document).

Vaccination and Post-Exposure Prophylaxis

Vaccination is the best protection against measles. MMR is a measles-containing vaccine that is highly effective in providing measles immunity. It is highly recommended that facilities keep records of their employees' vaccinations to facilitate a prompt response to a measles exposure, should one occur.

Post-exposure prophylaxis: Non-immune contacts >6mo can be vaccinated within 72 hours of exposure; if contraindications to vaccination exist, immune globulin (IG) may be administered within six days of exposure to prevent or ameliorate illness for certain high-risk groups including infants, immunocompromised persons, and non-immune pregnant persons.

- LHDs and HCPs should proactively assess the availability of IG in their networks so that high-risk exposed persons can be quickly connected to PEP if needed.

Clinicians should ensure all patients are up to date on MMR vaccination and prioritize timely administration of vaccination.

1. **Children:** The routine MMR vaccine schedule is a first dose at 12-15 months of age and a second dose at 4-6 years of age.
   - Vaccination is recommended as soon as possible upon reaching age 12 months.
   - Although a second dose is usually administered at 4-6 years of age, a valid second dose can be given earlier if administered at least 28 days after the first dose.
2. **Adults (non-high risk):** Adults born during or after 1957 should have at least one dose of the MMR vaccine, or presumptive evidence of immunity.

Additional recommendations for certain high-risk populations:

1. Students at post-high school educational institutions: Should have two doses of MMR, spaced out by at least 28 days, or evidence of immunity.
2. For individuals who are traveling internationally to any region or traveling domestically to an area with an ongoing outbreak:
   a. Infants 6 through 11 months of age
      - Traveling internationally: Should be given one dose of MMR vaccine. These children will still need their regular 2 MMR dose series starting at 12 months of age.
      - Traveling to domestic areas with ongoing outbreak: Clinicians should look to the vaccination guidance of the state or local health department for the residents of the outbreak-affected community to determine whether vaccination is needed. If a dose is given, the child will still need their regularly scheduled 2 MMR doses at 12 months of age and older.
      - Those who receive a vaccine before 12 months of age should additionally receive their 12–15-month vaccine on schedule.
   b. Individuals 12 months of age or older (both children and adults) should have two doses of MMR, separated by at least 28 days.
3. Healthcare personnel (HCP) (all paid and unpaid persons working in health-care settings): Should have presumptive evidence of immunity to measles.
   a. Presumptive evidence of immunity is defined as:
      - written documentation of vaccination with 2 doses of live measles or MMR vaccine administered at least 28 days apart,
      - laboratory evidence of immunity (positive serum IgG),
      - laboratory confirmation of disease, or
      - birth before 1957. *(According to CDC, although birth before 1957 is considered as presumptive evidence of immunity, for unvaccinated HCP born before 1957 that lack laboratory evidence of measles immunity or laboratory confirmation of disease, health care facilities should consider vaccinating personnel with two doses of MMR vaccine at the appropriate interval.)*
   b. Healthcare personnel who are non-immune should be excluded from work from day 5 of the first day of exposure through day 21 from the last (not first) day of exposure.

Additional Resources & References:

- IDPH: Measles
- IDPH Clinician Measles Mini-Toolkit
- IDPH: Measles Testing Instructions
- IDPH Measles Infection Prevention and Control Information for Health Care Facilities
- CDC Questions about Measles

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