GEORGIA DEPARTMENT *of* PUBLIC HEALTH

STD Pocket Guide

for HEALTHCARE PROFESSIONALS

GEORGIA DEPARTMENT OF PUBLIC HEALTH

REPORTABLE STDs

Reportable Immediately
Syphilis
Syphilis during pregnancy
Reportable within 7 days
Chlamydia trachomatis
Gonorrhea
Chancroid*
Lymphogranuloma venereum*
HIV infection
Perinatal HIV exposure

**These conditions are rarely diagnosed in Georgia and are not included in this guide*

Contents

A list of reportable diseases and conditions can be found at **dph.georgia.gov/disease-reporting**

Reporting STDs: Frequently Asked Questions

WHO MUST REPORT?

Every medical provider and laboratory must report STDs as required by law **(O.C.G.A. § 31-12-2)**.

DO I HAVE TO REPORT LAB RESULTS?

Yes.

WHY DO I NEED TO REPORT STDs?

The law requires reporting of specific STDs for **monitoring of disease occurrence, disease trends, disease outbreaks** and in some case investigations **(O.C.G.A. § 31-12-2)**.

DO I NEED A RELEASE OF INFORMATION FORM?

No. HIPAA allows the disclosure of public health information (PHI) for matters of public health **(45 CFR Part 164.512(b))** or www.hhs.gov/hipaa/for-professionals/special-topics/public-health/index.html).

WHERE DO I REPORT?

All reportable conditions can be reported through the **State Electronic Notifiable Disease Surveillance System** (SendSS). Register and find training at https://sendss.state.ga.us/.

CHLAMYDIA SCREENING RECOMMENDATIONS

FEMALE	• Sexually active women under 25 years of age • Sexually active women age 25 years and older if at increased risk **RETEST 3 MONTHS AFTER TREATMENT**
PREGNANT FEMALE	• All pregnant women under 25 years of age and older women if at increased risk. • Pregnant women with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months **RETEST DURING THE 3RD TRIMESTER FOR WOMEN UNDER 25 YEARS OF AGE OR AT RISK**
MALE	• Consider screening young men in high prevalence clinical settings or in populations with high burden of infection (e.g., MSM)
MALES WHO HAVE SEX WITH MALES (MSM)	• At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use **EVERY 3 TO 6 MONTHS IF AT INCREASED RISK**
PERSONS WITH HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter **MORE FREQUENT SCREENING** might be appropriate depending on individual risk behaviors and the local epidemiology

GONORRHEA SCREENING RECOMMENDATIONS

FEMALE	• Sexually active women under 25 years of age • Sexually active women age 25 years and older if at increased risk **RETEST 3 MONTHS AFTER TREATMENT**
PREGNANT FEMALE	• All pregnant women under 25 years of age and older women if at increased risk **RETEST 3 MONTHS AFTER TREATMENT**
MALES WHO HAVE SEX WITH MALES (MSM)	• At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use **EVERY 3 TO 6 MONTHS IF AT INCREASED RISK**
PERSONS WITH HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter **MORE FREQUENT SCREENING** might be appropriate depending on individual risk behaviors and the local epidemiology

SYPHILIS SCREENING RECOMMENDATIONS

PREGNANT FEMALES	• Pregnant females must be tested at the initial prenatal appointment and at the beginning of the 3rd trimester **GEORGIA LAW (O.C.G.A § 31-17-4.2)** **RETEST AT DELIVERY IF AT HIGH RISK**
MALES WHO HAVE SEX WITH MALES (MSM)	• At least annually for sexually active MSM **EVERY 3 TO 6 MONTHS IF AT INCREASED RISK**
PERSONS WITH HIV	• For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter **MORE FREQUENT SCREENING** might be appropriate depending on individual risk behaviors and the local epidemiology

HIV SCREENING RECOMMENDATIONS

FEMALE	• All women aged 13-64 years (opt-out) • All women who seek evaluation and treatment for STDs
PREGNANT FEMALE	• Pregnant females must be tested at the initial prenatal appointment and at the beginning of the 3rd trimester **GEORGIA LAW (O.C.G.A § 31-17-4.2)**
MALE	• All men aged 13-64 (opt-out) • All men who seek evaluation and treatment for STDs
MALES WHO HAVE SEX WITH MALES (MSM)	• At least annually for sexually active MSM if HIV status is unknown or negative and the patient himself or his sex partner(s) have had more than one sex partner since most recent HIV test

CHLAMYDIA TESTING AND SYMPTOMS

DIAGNOSTIC TESTING

The diagnosis process can include nucleic acid amplification tests (NAATs), cell culture and others. The most sensitive tests are the NAATs and they can be performed on specimens collected from the clinician or the patient (e.g., vaginal swabs or first-catch urine specimens). Culture can be used for rectal or pharyngeal specimens, but is not widely available as most tests are not FDA-cleared for use with these specimens. However, NAATs have been demonstrated to have improved sensitivity and specificity compared with culture for the detection of C. trachomatis at rectal sites and at oropharyngeal sites among men. Some laboratories have established CLIA-defined performance specifications when evaluating rectal and oropharyngeal swab specimens for C. trachomatis, thereby allowing results to be used for clinical management.

ADDITIONAL INFORMATION: www.cdc.gov/std/tg2015/chlamydia.htm.

SYMPTOMS

Most infected individuals are asymptomatic; however, some women have signs and symptoms of cervicitis and sometimes urethritis. If the infection spreads to the upper reproductive tract, symptoms might include abdominal and or pelvic pain, etc.

ADDITIONAL INFORMATION: www.cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm.

GONORRHEA TESTING AND SYMPTOMS

DIAGNOSTIC TESTING

Testing urine, urethral (for men) or endocervical or vaginal (for women) specimens using a NAAT can diagnose urogenital gonorrhea. Pharyngeal and/or rectal swab specimens can be tested through culture or NAAT. Some laboratories have met CLIA regulatory requirements and established performance specifications for using NAAT with rectal and oropharyngeal swab specimens that can inform clinical management.

ADDITIONAL INFORMATION: www.cdc.gov/std/tg2015/gonorrhea.htm.

SYMPTOMS

Many men and women may be asymptomatic. Men may experience urethral infection that includes dysuria or a white, yellow or green urethral discharge. Men who have epididymitis complications may also complain of testicular or scrotal pain. Women may have mild symptoms that resemble a bladder or vaginal infection. Some women have dysuria, increased vaginal discharge, or vaginal bleeding between periods. Rectal infection in both men and women may cause discharge, anal itching, soreness, bleeding or painful bowel movements. Pharyngeal infection may cause a sore throat. Both rectal and pharyngeal infections may be asymptomatic.

ADDITIONAL INFORMATION: www.cdc.gov/std/gonorrhea/stdfact-gonorrhea-detailed.htm.

SYPHILIS TESTING AND SYMPTOMS

DIAGNOSTIC TESTING

Definitive diagnosis can only be made by visualizing the Treponema pallidum bacterium via darkfield microscopy (rarely used). Most commonly, diagnosis is made using two (2) types of blood test available for syphilis:

- Nontreponemal test (e.g. VDRL and RPR) – often used for screening
- Treponemal test (e.g. FTA-ABS, TP-PA, EIA etc.) – traditionally used for confirmation

Sexual health and patient examination should be thorough as many patients either do not notice the signs and symptoms or believe they are resulting from something else (e.g., allergic reactions, skin conditions, etc.).

ADDITIONAL INFORMATION www.cdc.gov/std/tg2015/syphilis.htm.

SIGNS AND SYMPTOMS

Syphilis signs and symptoms may resemble other diseases. The following section will cover staging along with common signs and symptoms, however, detailing all the potential signs and symptoms of syphilis is beyond the scope of this pocket guide.

ADDITIONAL INFORMATION: www.cdc.gov/std/syphilis/stdfact-syphilis-detailed.htm.

SYPHILIS STAGES

PRIMARY STAGE SYPHILIS

- One or more chancres (usually firm, round, small and painless) appear at the site of infection 10 to 90 days after exposure.
- Chancres heal on their own in 3-6 weeks.
- Most infectious stage of infection.

Primary stage syphilis sore (chancre) on glans (head) of the penis.

Primary stage syphilis sore (chancre) on the surface of a tongue.

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SYPHILIS STAGES

SECONDARY STAGE SYPHILIS

- Rashes mark the second stage of syphilis symptoms.
- Rashes may present as a skin rash or mucous membrane lesions (sores in the mouth, vagina or anus) and occur as the chancre(s) begin to heal.
- In addition to rashes, symptoms of secondary syphilis may include fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches and fatigue

Palmar rash

Back rash

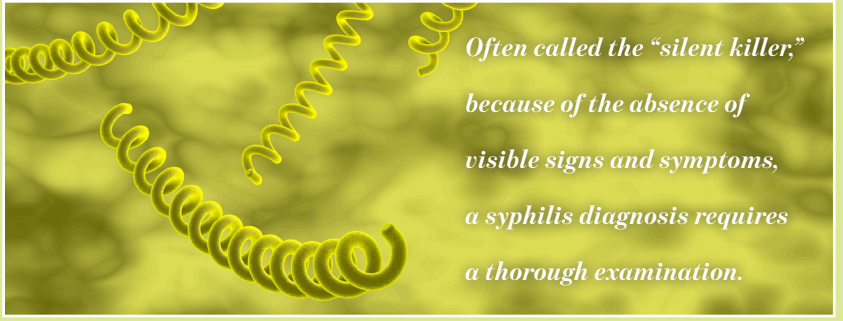
SYPHILIS STAGES

EARLY LATENT STAGE SYPHILIS

- No visible signs or symptoms of primary or secondary syphilis are present.
- Infection occurred within the past 12 months.

LATE LATENT STAGE SYPHILIS

- No visible signs or symptoms of primary or secondary syphilis are present.
- No evidence that the infection was acquired during the previous 12 months.



A definitive diagnosis can only be made by visualizing the Treponema pallidum bacterium (above) which cause syphilis, through rarely used darkfield microscopy. More commonly, two types of blood tests are used—the nontreponemal test—often used for screening, and the treponemal test— for a confirmed diagnosis.

SYPHILIS CLINICAL MANIFESTATIONS

OTHER CLINICAL MANIFESTATIONS

Clinical manifestations are possible at any stage of diagnosis including the following:

Neurological | Ocular | Otic

NEUROSYPHILIS (infection of the nervous system)

- Symptoms may include headache, altered behavior, difficulty coordinating muscle movements, paralysis, sensory deficits and dementia.

PATIENT IS A LIKELY CASE IF THE FOLLOWING APPLY:

- Reactive nontreponemal and treponemal tests
- Clinical symptoms or signs consistent with neurosyphilis without other known causes for the abnormalities
- Elevated cerebrospinal fluid (CSF) protein (>50 mg/dL) or leukocyte count (>5 white blood cells/cubic millimeter CSF) in the absence of other known causes of abnormalities

OCULAR SYPHILIS (infection of the eye)

- Symptoms include vision changes, decreased visual acuity & permanent blindness.

PATIENT IS A LIKELY CASE IF THE FOLLOWING APPLY:

- Reactive nontreponemal test and treponemal test
- Clinical symptoms or signs consistent with ocular syphilis without other known causes for the abnormalities
- Findings on exam by an ophthalmologist that are consistent with ocular syphilis in the absence of other known causes for these abnormalities

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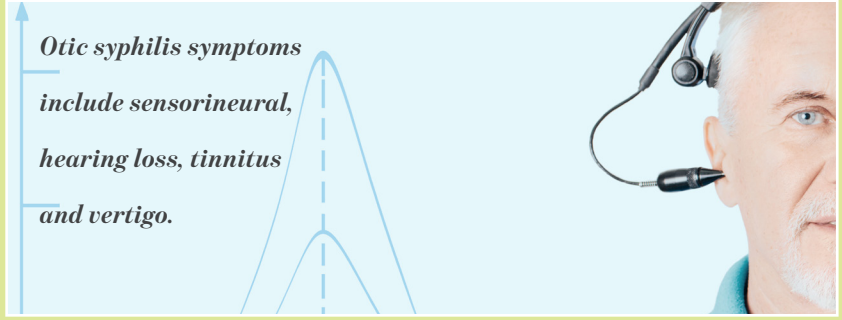
SYPHILIS CLINICAL MANIFESTATIONS

OTIC SYPHILIS (infection of the cochleovestibular system)

- Symptoms include sensorineural, hearing loss, tinnitus and vertigo.

PATIENT IS A LIKELY CASE IF THE FOLLOWING APPLY:

- Reactive nontreponemal test and treponemal test
- Clinical symptoms or signs consistent with otic syphilis without other known causes for the abnormalities
- Findings on exam by an ophthalmologist that are consistent with otic syphilis in the absence of other known causes for these abnormalities



Examining a patient's ears thoroughly is necessary in investigating any otic syphilis symptoms

HIV TESTING AND SYMPTOMS

DIAGNOSTIC TESTING

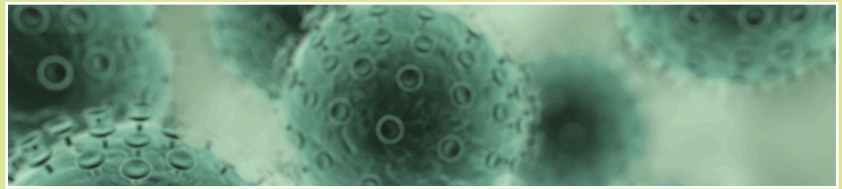
The recommended diagnostic algorithm for HIV infection consists of a laboratory-based immunoassay, which if repeatedly reactive is followed by an HIV-1/HIV-2 antibody differentiation assay.

ADDITIONAL INFORMATION: https://stacks.cdc.gov/view/cdc/50872.

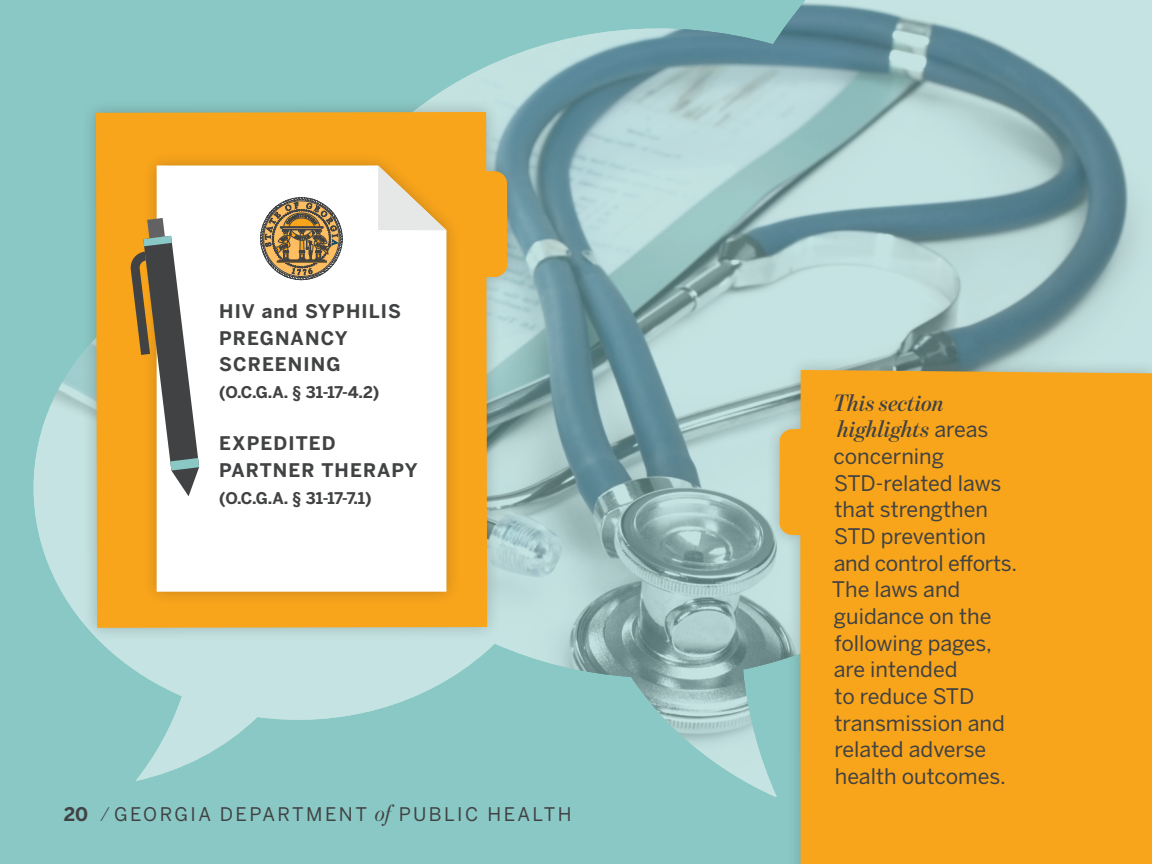
SIGNS AND SYMPTOMS

Some people may experience a flu-like illness within 2 to 4 weeks after infection (Stage 1 HIV infection). Other people may not feel sick during this stage. Flu-like symptoms include fever, chills, rash, night sweats, muscle aches, sore throat, fatigue, swollen lymph nodes, or mouth ulcers. These symptoms can last anywhere from a few days to several weeks.

ADDITIONAL INFORMATION: https://aidsinfo.nih.gov/guidelines and www.cdc.gov/hiv.



Human Immunodeficiency Virus (HIV) cells, which cause Acquired Immune Deficiency Syndrome (AIDS)



HIV and SYPHILIS PREGNANCY SCREENING
(O.C.G.A. § 31-17-4.2)

EXPEDITED PARTNER THERAPY
(O.C.G.A. § 31-17-7.1)

This section highlights areas concerning STD-related laws that strengthen STD prevention and control efforts. The laws and guidance on the following pages, are intended to reduce STD transmission and related adverse health outcomes.

GEORGIA LAW

CONGENITAL SYPHILIS & PERINATAL HIV PREVENTION

Georgia medical providers can help prevent congenital syphilis and mother-to-child HIV transmission by adhering to the following guidelines and law:

- **Screen** every pregnant woman for syphilis and HIV at initiation of prenatal care and in her 3rd trimester.
  - Test mother early in their 3rd trimester (preferably at 28 weeks). If she has syphilis and is treated at least 30 days prior to delivery, congenital syphilis can be prevented.
- **Report** all cases of syphilis and HIV to the local health department immediately for intervention and services. What should be reported:
  - Mother with positive syphilis and/or HIV labs
  - Baby born to mothers with untreated syphilis or treated syphilis within 30 days of delivery
  - Baby born to mother who has positive HIV labs
- **Treat** mother before the birth of baby.
  - Complete treatment for syphilis
  - Immediately initiate HIV treatment for HIV positive mother

GEORGIA LAW

EXPEDITED PARTNER THERAPY (EPT)

WHAT IS EPT?

EPT means the practice of prescribing, ordering, or dispensing antibiotic drugs to the sexual partner or partners of an index patient diagnosed with chlamydia, without a physical examination of such partner or partners.

IS EPT LEGAL IN GEORGIA?

Yes, EPT is legal. Since 2017, Georgia law has supported medical providers using EPT for treatment of sex partners of patients diagnosed with chlamydia through **(O.C.G.A. § 31-17-7.1)** along with Rules of the Department of Public Health **511-2-8**.

IS MY PROFESSIONAL LICENSE IN JEOPARDY FOR PRESCRIBING OR DISPENSING MEDICATION FOR PATIENTS I HAVEN'T SEEN?

No. If the antibiotic is prescribed or dispensed in accordance with **(O.C.G.A. § 31-17-7.1)** and Rule **511-2-8** you will not be subject to civil or criminal liability and shall not be deemed to have engaged in unprofessional conduct by your respective licensing board.

STD TREATMENT GUIDELINES

Prescription guidelines for STD infections are of primary importance to help contain the spread of STDs.

Summary guidelines from the 2015 CDC Guidelines for Treatment of Sexually Transmitted Diseases is being provided. However, this guide only provides treatment guidelines for commonly reported infections: gonorrhea, chlamydia and syphilis.

This includes information from the most recent treatment recommendation guide published by the CDC to date for these conditions.

More STD treatment recommendations can be found at www.cdc.gov/std/tg2015/default.htm, or by contacting your local health department.

Detailed and regularly updated recommendations for the initial management of persons with HIV infection and pregnancy are available in existing guidance at http://aidsinfo.nih.gov/guidelines. The local Ryan White clinic and www.gacapus.com/r/ can also be used as a resource.

CHLAMYDIAL INFECTIONS

PATIENT TYPE	RECOMMENDED RX DOSE/ROUTE	ALTERNATIVES DOSE/ROUTE
ADULTS AND ADOLESCENTS	• **Azithromycin** **1 g orally** in a single dose ***OR*** • **Doxycycline** **100 mg orally** 2x/day for 7 days	• **Erythromycin base** **500 mg orally** four times a day for 7 days ***OR*** • **Erythromycin ethylsuccinate** **800 mg orally** four times a day for 7 days ***OR*** • **Levofloxacin** **500 mg orally** once daily for 7 days ***OR*** • **Ofloxacin** **300 mg orally** twice a day for 7 days
PREGNANCY	• **Azithromycin** **1 g orally** in a single dose	• **Amoxicillin** **500 mg orally** three times a day for 7 days ***OR*** • **Erythromycin base** **500 mg orally** four times a day for 7 days ***OR*** • **Erythromycin base** **250 mg orally** four times a day for 14 days ***OR*** • **Erythromycin ethylsuccinate** **800 mg orally** four times a day for 7 days ***OR*** • **Erythromycin ethylsuccinate** **400 mg orally** four times a day for 14 days

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CHLAMYDIAL INFECTIONS *Continued*

PATIENT TYPE	RECOMMENDED RX DOSE/ROUTE	ALTERNATIVES DOSE/ROUTE
INFANTS AND CHILDREN (<45 kg) urogenital, rectal	• **Erythromycin base** ***OR*** **ethylsuccinate 50 m/kg/day orally** (4 divided doses) daily for 14 days	**Data are limited** on the effectiveness and optimal dose of azithromycin for chlamydial infection in infants and children <45 kg
NEONATES: opathalmia neonatorum, pneumonia	• **Erythromycin base** ***OR*** **ethylsuccinate 50 m/kg/day orally** (4 divided doses) daily for 14 days	• **Azithromycin 20 mg/kg/day orally,** 1 dose daily for 3 days

GONOCOCCAL INFECTIONS

PATIENT TYPE	RECOMMENDED RX DOSE/ROUTE	ALTERNATIVES DOSE/ROUTE
ADULTS, ADOLESCENTS: uncomplicated gonococcal infections of the cervix, urethra, and rectum	• **Ceftriaxone 250 mg IM** in a single dose ***PLUS*** • **Azithromycin 1g orally** in a single dose	**If Ceftriaxone** is not available: • **Cefixime 400 mg orally** in a single dose ***PLUS*** • **Azithromycin 1 g orally** in a single dose ***OR*** **If cephalosporin allergy:** • **Gentamicin 240 mg IM** single dose ***PLUS*** • **Azithromycin 2 g orally** in a single dose
PHARYNGEAL	• **Ceftriaxone 250 mg IM** in a single dose ***PLUS*** • **Azithromycin 1 g orally** in a single dose	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to **www.CDC.gov/std/tg2015/gonorrhea.htm**

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GONOCOCCAL INFECTIONS *Continued*

PATIENT TYPE	RECOMMENDED RX DOSE/ROUTE	ALTERNATIVES DOSE/ROUTE
PREGNANCY	• **Ceftriaxone 250 mg IM** in a single dose ***PLUS*** • **Azithromycin 1 g orally** in a single dose	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to **www.CDC.gov/std/tg2015/gonorrhea.htm**
ADULTS AND ADOLESCENTS: conjunctivitis	• **Ceftriaxone 1 g IM** in a single dose ***PLUS*** • **Azithromycin 1 g orally** in a single dose	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to **www.CDC.gov/std/tg2015/gonorrhea.htm**
CHILDREN: (≤ 45 kg): and Who Have Uncomplicated Gonococcal Vulvovaginistis, Cervicitis, Urethritis, Pharyngitis, or Proctitis	• **Ceftriaxone 25–50 mg/kg IV or IM**, not to exceed **125 mg IM** in a single dose	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to **www.CDC.gov/std/tg2015/gonorrhea.htm**

GONOCOCCAL INFECTIONS *Continued*

PATIENT TYPE	RECOMMENDED RX DOSE/ROUTE	ALTERNATIVES DOSE/ROUTE
CHILDREN: (> 45 kg): and Who Have Uncomplicated Gonococcal Vulvovaginistis, Cervicitis, Urethritis, Pharyngitis, or Proctitis	• Treat with one of the regimens recommended for adults (see Gonococcal Infections)	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to **www.CDC.gov/std/tg2015/gonorrhea.htm**
NEONATES: OPHTHALMIA NEONATORUM PROPHYLAXIS	• **Erythromycin (0.5%)** ophthalmic ointment in each eye in a single application at birth	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to **www.CDC.gov/std/tg2015/gonorrhea.htm**

SYPHILIS INFECTION

PATIENT TYPE	RECOMMENDED RX DOSE/ROUTE	ALTERNATIVES DOSE/ROUTE
PRIMARY, SECONDARY, OR EARLY LATENT <1 year	• **Benzathine penicillin G 2.4 million units IM** in a single dose	• **Doxycycline 100 mg** 2x/day for 14 days ***OR*** • **Tetracycline 500 mg orally** 4x/day for 14 days
LATENT >1 year, latent of unknown duration	• **Benzathine penicillin G 2.4 million units IM** in 3 doses each at 1 week intervals (**7.2 million units total**)	• **Doxycycline 100 mg** 2x/day for 28 days ***OR*** • **Tetracycline 500 mg orally** 4x/day for 28 days
PREGNANCY	Pregnant women should be treated with the penicillin regimen appropriate for their stage of infection	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to **www.cdc.gov/std/tg2015/syphilis-pregnancy.htm.****

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SYPHILIS INFECTION *Continued*

PATIENT TYPE	RECOMMENDED RX DOSE/ROUTE	ALTERNATIVES DOSE/ROUTE
NEUROSYPHILIS *AND* OCULAR SYPHILIS	• **Aqueous crystalline penicillin G 18–24 million units** per day, administered as **3–4 million units IV** every 4 hours or continuous infusion, for 10–14 days	• **Procaine penicillin G 2.4 MU IM** 1x daily ***PLUS*** • **Probenecid 500 mg orally** 4x/day, both for 10-14 days.
TERTIARY SYPHILIS (gummas and cardio-vascular) with Normal CSF Examination	• **Benzathine penicillin G 2.4 million units IM** in 3 doses each at 1 week intervals (**7.2 million units total**)	• **Doxycycline 100 mg** 2x/day for 28 days ***OR*** • **Tetracycline 500 mg orally** 4x/day for 28 days

SYPHILIS INFECTION *Continued*		
PATIENT TYPE	**RECOMMENDED RX DOSE/ROUTE**	**ALTERNATIVES DOSE/ROUTE**
CONGENITAL SYPHILIS	• See complete **CDC guidelines.***	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to www.CDC.gov/std/tg2015/syphilis.htm
CHILDREN: PRIMARY, SECONDARY, OR EARLY LATENT < 1 year	• **Benzathin penicillin G 50,000 units/kg IM** in a single dose (maximum **2.4 million units**)	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to www.CDC.gov/std/tg2015/syphilis.htm
CHILDREN: LATENT, > 1 year, latent of unknown duration	• **Benzathine penicillin G 50,000 units/kg IM** for 3 doses at 1 week intervals (maximum total **7.2 million units**)	Alternative regimens are unavailable in the current guidelines. Consult an expert in STD care and refer to www.CDC.gov/std/tg2015/syphilis.htm

* More syphilis treatment recommendations for pregnancy, congenital syphilis, clinical manifestation and alternative therapy in patients with penicillin allergy is available at **www.cdc.gov/std/tg2015/default.htm**.

** Pregnant females with penicillin allergies should be desensitized and treated with the penicillin regimen appropriate for her stage of infection to prevent maternal transmission to the fetus and treat fetal infection.

NOTE: Refer to the current 2015 STD guidelines for the treatment of other STDs in individuals living with HIV. **www.cdc.gov/std/tg2015/default.htm**

Why Do Communicable Disease Specialists (CDS) Matter to Providers?

Highly skilled health professionals referred to as communicable disease specialists (CDS), also known as disease intervention specialists (DIS), specialize in disease investigative skills. These CDS are very knowledgeable of STD diagnosis and CDC treatment recommendations. They often use their expertise to conduct the following public health activities:

PARTNER SERVICES may be provided to sex partners and needle sharing partners which may include exposure notification, STD education and linkage to care services.

MEDICAL RECORD EXTRACTIONS may be conducted to ensure case reports include pertinent patient information necessary for public health investigations.

DISEASE COUNSELING AND EDUCATION may be provided to individuals with positive test results in need of medical care.

CDS MAY CONTACT BOTH PATIENTS AND PROVIDERS FOR ANY OF THE REASONS LISTED ABOVE. FOR MORE INFORMATION, CONTACT YOUR LOCAL HEALTH DEPARTMENT STD PROGRAM.

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