KAMS Diphtheria Guidance

1. Policy Statement

Staff should refer to the WA diphtheria outbreak case and contact management interim guidance and CDNA Interim guidance for diphtheria outbreak management for the most current principles and actions regarding case definitions. The state and national guidance outlines the key response actions and principles for interventions during diphtheria outbreaks to ensure consistency in identifying confirmed, probable, and suspected case. The KAMS document includes guidance on internal management that aligns with Kimberley Population Health Unit advice, and State and CDNA guidelines.

Certain criteria within this document is subject to change depending on the outbreak level. Please routinely check for updates and avoid printing.

2. Procedures

The following sections outline the process of management of Diphtheria cases and contacts.

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Notification Processes

Notifications of new cases will come through the Kimberley Population Health Unit (KPHU).

- KPHU will notify the relevant **Clinic Manager** and **Infection Prevention and Control personnel**.
- Staff receiving the notification from KPHU must notify via email:
    - Medical Director
    - Remotes Executive Manager
    - Senior Medical Officer
    - Public Health Registrar

Management of Suspected and Confirmed Cases

Staff caring for suspected or confirmed cases of diphtheria should adhere to standard, contact and droplet precautions until 72 hours of antibiotic treatment completed. This includes donning PPE for close contact and wound care, including wearing:

- Gloves
- Gowns
- Surgical mask

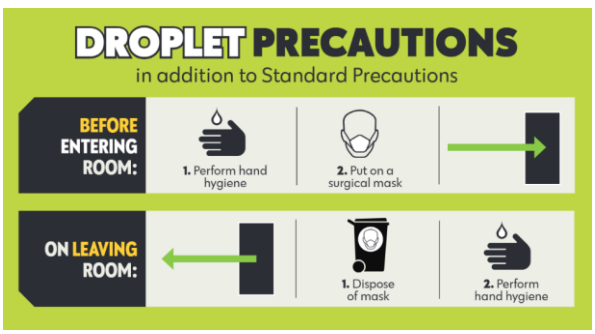
Additionally:

- For patients with cutaneous diphtheria ensure wounds are covered with waterproof, occlusive dressing.
- For all patients presenting to the clinic with suspected or confirmed diphtheria, ask them to wear a surgical mask.
- All cases should be advised to avoid contact where possible with people beyond their household at least for the duration of their antibiotic course.
- Provide all confirmed and suspected cases with a Factsheet.
- Utilise isolation room.

For further guidance on PPE and Cleaning refer to: DOC_2147 KAMS Standard and Transmission Based Precaution Guideline.

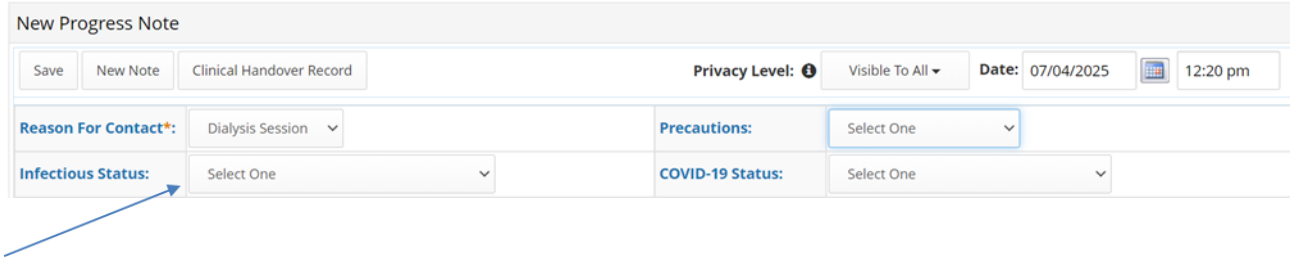
For signage: Standard and Transmission Based Precautions Signage.

Complete Contact Tracing and Treatment Protocol for each case as detailed below.



Documentation for tracking

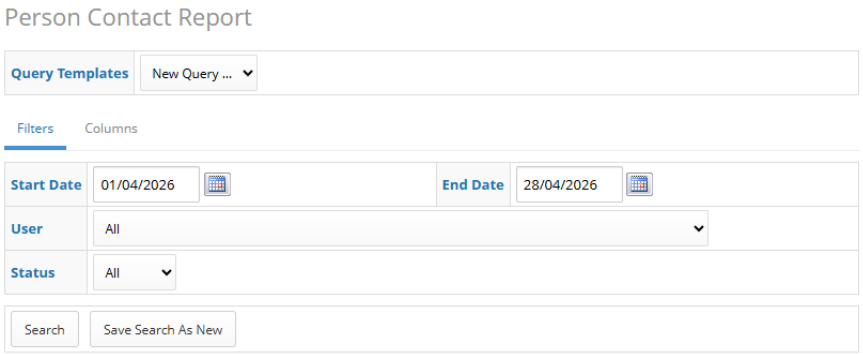
Ensure the patient has been documented as a ‘Diphtheria’ or ‘Diphtheria close contact’ case using the Infectious Status drop down in progress notes. This allows for MMEx reports on current cases and close contacts.

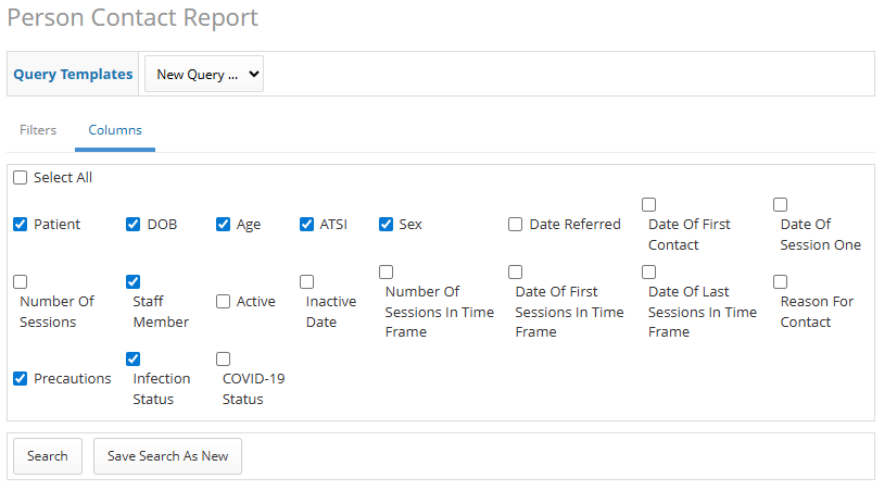


To run a report on the flagged cases:

1. Navigate to Forms and Reports
2. Click ‘Person Contact via Progress Notes’
3. In ‘Filters’ sections ensure under ‘Users’ that ‘All’ is selected
4. Enter in relevant dates
5. Select ‘Columns’
6. Unselect categories not required for report
7. Click search
8. Export to excel for data cleaning

Example:





Testing

- Suspect respiratory diphtheria in cases of exudative tonsillitis, or those who are very unwell with fever, enlarged cervical lymph nodes and upper respiratory tract infection symptoms.
    - For those with respiratory symptoms, also take POCT for Strep A
- Suspect cutaneous diphtheria in cases with slow healing or non-healing wounds, or wounds that appear punched out with a blue/grey tinge.
- **Alert the senior GP before testing for diphtheria – antibiotics should be commenced for symptomatic patients prior to receiving results.**

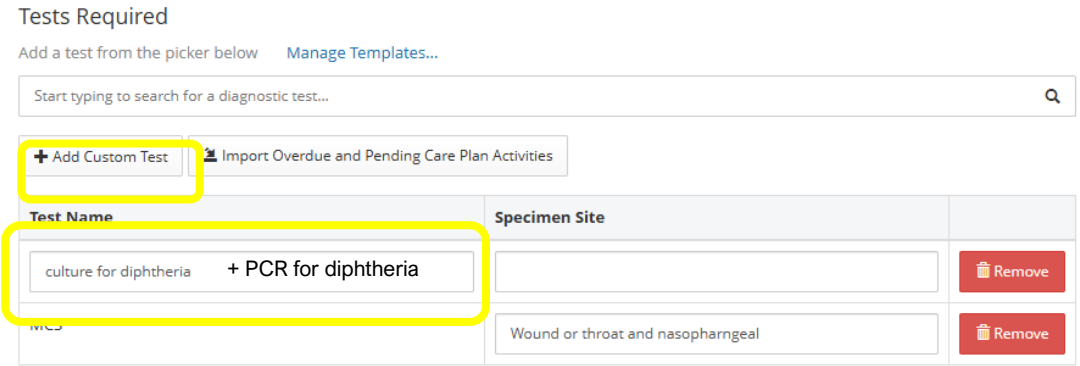
Swabs

- Two swabs need to be collected for throat and wound swabs for 1) PCR and 2) MC+S
- Collect throat and nasopharyngeal swab (use same swab) and/or skin swabs using an **orange dry swab for PCR AND charcoal swab for MC+S** (pictured below).
    - If you suspect cutaneous diphtheria you must ALSO take a throat and nasopharyngeal swab for diphtheria.
- Ensure you **free text 'PCR and culture for diphtheria'** on the pathology request form.
- The results will return in 2 stages: the PCR result will show presence of diphtheria toxin gene; the second MC+S result will show growth of *C Diphtheriae* or *C Ulcerans* bacteria. **If the PCR is positive treat for confirmed diphtheria, do not wait for MC+S result.**
- If you need to order additional supplies of dry or charcoal swabs, please order directly through PathWest's Clinic Supply Order Form.

Charcoal swab

Dry swab

Request should look like:



Treatment

There are two pathways for **toxigenic positive Diphtheria** treatment, based on type of infection (respiratory versus cutaneous). Treatment of confirmed cases and contacts is in accordance with the WA diphtheria outbreak case and contact management interim guidance as of 8 May 2026. Treatment of **toxigenic negative diphtheria** is also included below.

Confirmed Respiratory Diphtheria Toxigenic Positive

If you are suspecting respiratory diphtheria in a symptomatic patient, commence antibiotic treatment EARLY. Do not wait for the results of the swabs as there can be a delay.

Respiratory Diphtheria Toxigenic POSITIVE	
Alert	▪ Alert the Senior GP on-call for management guidance for all respiratory diphtheria ▪ Issue URGENT patient recall
Treatment	▪ If the patient is clinically **stable** and can safely swallow, prescribe: PO Azithromycin 500mg (child: 10mg/kg up to 500mg) once daily for 7 days ▪ Where there are contraindications to azithromycin or concerns about adherence to oral antibiotics, consider alternative agents, such as single dose 900mg IM LAB in discussion with infectious diseases physician or clinical microbiologist. ▪ Ensure appropriate treatment of other organisms consistent with the clinical presentation (e.g. streptococcal throat infections) ▪ If the patient is clinically **unstable** or at risk of airway compromise (significant neck swelling, presence of a pseudomembrane in the throat, difficulty breathing, signs of sepsis), they will require transfer out of community for respiratory support and consideration of Diphtheria Anti-Toxin (DAT) Commence IV Benzylpenicillin 1.2g (child: 50mg/kg up to 1.2g) 6 hourly + IV Azithromycin 500mg (child: 10mg/kg up to 500mg) daily ▪ All severe cases also require an ECG, IV lines, Chem 8/CG4+, blood cultures and baseline neurological and cranial nerve examination.
Contact tracing	▪ Begin contact tracing for all contacts in **previous 72 hours before symptom onset** for all confirmed diphtheria on MC+S swab. Do not wait for toxigenic report as this will delay contact tracing. See *Contact tracing* page 8-10.
Follow-up	▪ If the patient remains in community, **provide daily clinical check-in**, either via home visit or telephone.
Isolation and clearance	▪ Cases should be **excluded from work, school and childcare** until they have completed antibiotics ▪ Clearance testing is not routinely recommended. If the patient remains symptomatic despite 7 days of antibiotic treatment, consider re-testing with a throat/nasopharyngeal swab and continuing antibiotics for a further 7 days.
Vaccination	▪ Give a booster dose of dTpa if **greater than 12 months** since last dose when case is recovering from acute illness. Liaise with the Senior GP regarding timing of this.

Confirmed Cutaneous Diphtheria Toxigenic Positive

If you are suspecting cutaneous diphtheria in a symptomatic patient, commence antibiotic treatment EARLY. Do not wait for the results of the swabs as there can be a delay.

Cutaneous Diphtheria Toxigenic POSITIVE	
Alert	▪ Alert the Senior GP on-call for management guidance for all cutaneous diphtheria ▪ Issue URGENT patient recall
Treatment	▪ Cover would with occlusive water proof dressing ▪ Prescribe PO Azithromycin 500mg (child: 10mg/kg up to 500mg) once daily for 7 days ▪ Where there are contraindications to azithromycin or concerns about adherence to oral antibiotics, consider alternative agents such as single dose 900mg IM LAB in discussion with infectious diseases physician or clinical microbiologist. ▪ Ensure appropriate treatment of other organisms consistent with the clinical presentation (e.g. identified on wound swabs - *Staphylococcus* and *Streptococcus* are frequently co-isolated)
Contact tracing	▪ Begin contact tracing for all contacts in **previous 72 hours of symptom onset** for all confirmed diphtheria on MC+S swab. Do not wait for toxigenic report as this will delay contact tracing. See *Contact tracing* page 8-10.
Follow-up	▪ If the patient remains in community, **provide regular clinical check-in**, either via home visit or telephone.
Isolation and clearance	▪ Cases should be **excluded from work, school and childcare** until they have taken 72 hours of antibiotics
Vaccination	▪ Give a booster dose of dTpa if **greater than 12 months** since last dose when case is recovering from acute illness. Liaise with the Senior GP regarding timing of this.

Diphtheria toxigenic NEGATIVE (respiratory and cutaneous)

If the diphtheria culture returns toxigenic NEGATIVE, complete 7 days antibiotics, contact tracing can be ceased and no further case management or isolation is required.

Transfer out of Community

Follow usual protocols for transfer out of community based on acuity. Severe Diphtheria will need transfer to Broome Regional Hospital for anti-tox medication.

- If the patient is clinically unstable or at risk of airway compromise (significant neck swelling, presence of a pseudomembrane in the throat, difficulty breathing, signs of sepsis), they will require transfer out of community for respiratory support and consideration of Diphtheria Anti-Toxin (DAT)
    - Whilst awaiting transfer commence IV Benzylpenicillin 1.2g (child: 50mg/kg up to 1.2g) 6 hourly + IV Azithromycin 500mg (child: 10mg/kg up to 500mg) daily

ETS Script
Ensure that the ETS script includes context that the Kimberley region is currently experiencing a diphtheria outbreak and that if there is clinical or epidemiological suspicion of diphtheria, the closest anti-tox medication is at Broome Regional Hospital.

Clearance of Cases

Clearance testing of cases is not routinely recommended. If the patient remains symptomatic despite 7 days of antibiotic treatment, consider re-testing with a throat/nasopharyngeal swab and continuing antibiotics for a further 7 days. **Cases should be advised to stay at home and minimise contact with the community until antibiotic treatment is complete.**

Contact tracing:

- At present, around **80-90% of culture C diph. Cases in the Kimberley end up being confirmed toxigenic**. To ensure we are providing timely response, we are managing the culture positive cases and identifying and treating their contacts, as though they are toxin confirmed from the start, while we are waiting for toxin results.
    - Occasionally, we find out that case is toxigenic negative, in which case no more contact tracing needs to be done.
- Take a contact tracing history from the patient and/or guardian.
- Attend the positive cases home to take a contact tracing history.
  This helps prevent spread in the clinic and can give an idea of household contacts.
- Each contact will be classified as HIGH, MEDIUM or LOW risk, depending on their exposure. Please see Table 1.
    - The risk category will determine the management.
- Please use the KAMS Diphtheria Contact Tracing Live Spreadsheet to keep track of contact names and ongoing management.
    - Please DO NOT edit the rows of the spreadsheet. It has been purposely matched to KPHU reporting rows to ensure ease of information sharing.
    - If you cannot access the spreadsheet but have a case in clinic or community, do not delay recording details. Utilise Appendix 1 – Contact tracing sheet and transfer to the spreadsheet as soon as possible.
    - Spreadsheets to be supplied to KPHU each COB by PH Reg or delegate

  The links for each clinic Contact Tracing Spreadsheets are located here:
  - Beagle Bay
  - Bidyadanga
  - Balgo
  - Billiluna
  - Mulan

- See Appendix 3 for AHCWA patient facing resources for contact tracing.

Table 1: Close contact risk stratification.

Risk category	Contact Tracing Criteria **Respiratory**	Contact Tracing Criteria **Cutaneous**
HIGH	Household contact Close travel contact Intimate partner Close range respiratory exposure – direct exposure of mucous membranes to respiratory secretions or droplets (e.g. being coughed or sneezed on at close range) Healthcare worker - direct unprotected exposure during airway procedures (e.g. intubation).	Household contact or intimate partner and had direct contact with skin lesions, dressings or contaminated items (towels/bedding) Direct exposure to infected wound without appropriate PPE.
MEDIUM	Close contact in shared indoor space ≥8 hours (e.g. classroom, childcare) with no direct secretion/droplet exposure Healthcare worker contact without appropriate PPE, but no direct secretion exposure or uncertain level of exposure.	Indirect prolonged exposure ≥20 hours cumulative when wound uncovered e.g. shared living space, childcare. Healthcare worker contact with wound without appropriate PPE, but no risk of droplet generation during contact or uncertain level of exposure.
LOW	Causal or indirect contact (e.g. same school or workplace without close exposure) Healthcare workers no exposure to respiratory droplets nor direct contact with respiratory secretions.	Causal or indirect contact (e.g. same school or workplace without close exposure) Healthcare workers no direct exposure to skin lesions or wound droplets.

Management of Contacts

HIGH Risk Contacts

- Take a **nasopharyngeal swab/throat and cutaneous swab if contacts are symptomatic or lesions are present**. Asymptomatic contacts do not need to be tested, **if** they are provided with chemoprophylaxis +/- booster vaccination, but may be considered if the contact attends high-risk locations i.e. healthcare facility, school, childcare
    - Specify 'diphtheria culture' and 'diphtheria close contact' on the pathology form
- Offer a diphtheria containing **vaccination** (Boostrix, Adacel) if the contact has not had one in the last 12 months
    - If contact has not completed primary vaccination course: commence or complete primary / catch-up course.
- Symptomatic contacts: give PO Azithromycin 500mg (child: 10mg/kg up to 500mg), once daily, for 7 days as **presumed treatment**. Can also consider 900mg IM LAB if there are concerns with adherence.
- Asymptomatic contacts: give PO Azithromycin 500mg (child: 10mg/kg up to 500mg), once daily, for 5 days as **prophylactic antibiotics**
- Where possible, avoid contact with vulnerable populations (e.g. elderly, immunocompromised, young infants). Healthcare workers should not return to work until completion of 72 hours of antibiotics or when returned a negative test
- Advise to monitor for symptoms for 7 days.

MEDIUM Risk Contacts

- Take a **nasopharyngeal swab/throat and cutaneous swab** if contacts are symptomatic or lesions are present. Asymptomatic contacts do not need to be tested, **if** they are provided with chemoprophylaxis +/- booster vaccination, but may be considered if the contact attends high-risk locations i.e. healthcare facility, school, childcare
    - Specify 'diphtheria culture' and 'diphtheria close contact' on the pathology form
- Offer a diphtheria containing **vaccination** (Boostrix, Adacel) if the contact has not had one in the last 12 months
    - If contact has not completed primary vaccination course: commence or complete primary / catch-up course.
- Give PO Azithromycin 500mg (child: 10mg/kg up to 500mg), once daily, for 5 days as **prophylactic antibiotics.** Can also consider 900mg IM LAB if there are concerns with adherence.
- Healthcare workers should wear a mask at work until completion of 72 hours of antibiotics or when returned a negative test
- Advise to monitor for symptoms for 7 days.

LOW Risk Contacts

- Advise to monitor for symptoms for 7 days.
- Offer a diphtheria containing **vaccination** (Boostrix, Adacel) if the contact has not had one in the last 5 years
    - If contact has not completed primary vaccination course: commence or complete primary / catch-up course.

Vaccination of the Community

Vaccination criteria is subject to change depending on the outbreak level. Please routinely check for updates to this section via LogiQC Doc_4375.

Main points:	• Opportunistically offer vaccination check to any community member attending the clinic. • Encourage cases or close contacts to talk to people about the vaccine and attend the clinic to check their status if they are worried. • Use **Boostrix or Adacel** for vaccination to cover for pertussis booster.
Community	• Offer booster dTpa vaccine if 5 years or more since last dose for Aboriginal adult patients • Actively recall any patient who has not completed primary course or is due a dTpa vaccine as per the WA Health Immunisation Schedule
Cases	• Vaccinate with dTpa vaccine if 1 year or more since last dose once starting to recover from acute infection
Close contacts	• Vaccinate high risk and medium risk close contacts if it has been over 1 year since last dTpa vaccine
Health care workers	• Recommend booster dTpa vaccine if 5 years or more since last dose *as per WA Health Immunisation Schedule update 30 April 2026*
Non-Aboriginal patients	• Non-Aboriginal patients living in the Kimberley are eligible for a booster dTpa vaccine if 5 years or more since last dose as *per WA Health Immunisation Schedule update 30 April 2026* • Eligible for free vaccine if HCW or pregnant or have not completed primary course as per WA Health Immunisation Schedule

Vaccinator Parameters

For Nurses, Midwives, AHPs, AHWs to maintain practice within the immunisation SASA – any vaccine given outside of the current WA Immunisation Schedule should be prescribed by a member of the medical team. **Contact an onsite or on-call GP for prescribing a diphtheria containing vaccine if not within WA Immunisation Schedule criteria.**

Vaccine Competency

All staff providing vaccinations should be up to date with the 2026 Vaccine Update and Cold Chain training on the WA Health Rise platform to meet criteria for administering the dTpa vaccines under a SASA if this becomes available.

Link to training: https://immunisation-education.reach360.com/learn/my-learning

Vaccine Ordering

Ensure adequate stock of Boostrix and Adacel at clinic level, aim for 50 vaccinations.
Vaccination Clinicians will be contacting clinics to keep current stock levels updated to ensure rapid re-stocking available if required.

Outbreak Support

KAMS has stood up an Outbreak Management Team (OMT) in response to the outbreak.

- If you require resources or clinical support, please reach out to the Public Health Registrar at carla.deangelis@kamsc.org.au
- If you require support with vaccines, please email vaccinesupport@kamsc.org.au
- If you require support with, or urgent extra medication, please contact KPS pharmacy
- If you require support with IP&C advice and support please contact IP&C Coordinator at infectioncontrol@kamsc.org.au
- After hours Public Health Physician - 1800 434 122
  Any cases on the weekend will be called through from the on-call Public Health Physician. Call back this number if you need to return a call.

Additionally, KPHU has designated a Public Health Nurse to coordinate the response for the Kimberley region. Their contact details:

Marama Haenga Regional Immunisation Coordinator
T: (08) 9194 1640 | **M**: 0488 255 596 | **Confidential Fax**: (08) 9194 1631
E: marama.haenga@health.wa.gov.au

Definitions

Enter definitions of terms used in this document to help give the reader context.

TERM	DEFINITION
Case	A person with laboratory confirmed toxigenic positive diphtheria.
Contact	In this scenario, a contact is a person who has had contact with a confirmed case within their infectious period.
Diphtheria	A highly contagious, and potentially life-threatening, bacterial disease caused by *Corynebacterium diphtheria* or *Corynebacterium ulcerans*. Diphtheria usually affects a person's nose, throat, and windpipe, but it can also infect their skin. The skin infection is not generally severe, but the bacteria can spread to others and may cause the more severe respiratory form of illness. Toxigenic positive diphtheria releases a toxin that causes widespread inflammation in the body.
dTpa	Diphtheria, tetanus, pertussis – referring to combination vaccine.
Personal Protective Equipment (PPE)	Equipment which is intended to be worn or used by healthcare workers to promote patient and personal safety against infection risks e.g. gloves / aprons / eye protection / mask.
SASA	Structured Administration and Supply Arrangement – a legal agreement that allows non-medication endorsed Nurses, Midwives, AHPs and AHWs to administer medications under strict criteria.
Standard Precautions	The minimum level of infection prevention practices applied in all healthcare situations, regardless of infection status.
Transmission based precautions	Additional measures used for patients known or suspected to have infectious diseases that can spread via contact, droplet, or airborne routes.

Roles and Responsibilities

All Staff
Comply with instructions included within this guidance, and with KPHU advise as arising.

Medical Director
Oversee and coordinate outbreak response.

Public Health Registrar
Support outbreak response through contract tracing oversight, clinical advice coordination for vaccines and treatment and provide education on request.

Vaccine Clinicians
Provide support with vaccination of community.

IPCC
Provide support with IP&C and staff vaccinations.

Related Documents

The following documents are required to give effect to this policy:

- Doc_2147 KAMS Standard and Transmission Based Precaution Guideline.
- Doc_2148 KAMS Infection Prevention and Control Policy
- Doc_2130 Management of Occupational Exposure to Blood and Body Fluids
- Doc_735 Staff Vaccine Preventable Diseases (VPD) Policy
- Doc_2131 Management of Health Care Workers with Infectious Diseases
- Doc_2245 Poster – Standard and Transmission Based Precautions

Additional Resources

KAMS Education

- Diphtheria PowerPoint from KAMS Public Health Registrar and Senior Medical Officer KAMS Diphtheria Review 17.4.pptx

Factsheets

- Aboriginal Health Council of Western Australia brochure
- Kimberley Population Health Unit Diphtheria factsheet

Poster for Clinic

- Kimberley Population Health Unit Diphtheria Poster

Australian Communicable Disease Centre

- National Notifiable Disease Surveillance System
  National case numbers and demographic information
- Epidemiology report
- Interim Diphtheria Guideline

WA Health
Case numbers by region

- Western Australia Notifiable Infectious Disease Dashboard
- WA diphtheria outbreak case and contact management interim guidance

Vaccination Resources

- Western Australian Immunisation Schedule
- WA Health Annual Vaccine Training Modules

SASAs

- WA Health SASA Nurse Vaccinators
- WA Health SASA AHPs Vaccinators
- KAMS Diphtheria SASA TBA

References

1. Aboriginal Health Council of Western Australia. Diphtheria. Webpage accessed on 27/04/2026 from https://www.ahcwa.org.au/2026/03/06/diphtheria/

2. Australian Centre for Disease Control. CDNA Interim guidance for diphtheria outbreak. April 2026. Accessed 27/04/2026 from https://www.cdc.gov.au/sites/default/files/2026-04/cdna-interim-guidance-for-diphtheria-outbreak-management_1.pdf

3. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. – version 2. Preventing and Controlling Infections Standard. Sydney: ACSQHC; 2021.

4. Australian Commission on Safety and Quality in Health Care. Standard and transmission-based precautions posters. Accessed on 05/03/25 from https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/standard-and-transmission-based-precaution-posters

5. National Health and Medical Research Council (2019) Australian Guidelines for the Prevention and Control of Infection in Healthcare. Canberra: Commonwealth of Australia.

6. The Royal Australian College of General Practitioners. Infection prevention and control standards for general practices and other office-based and community-based practices. 5th ed. East Melbourne, Victoria: RACGP; 2024.

7. Therapeutic Guidelines (2026): Pharyngeal Diphtheria. Melbourne. Retrieved 27/04/2026 at https://app.tg.org.au/viewTopic?etgAccess=true&guidelinePage=Antibiotic&topicfile=bartonella-infections&guidelinename=auto&sectionId=c_ABG_Pharyngeal-diphtheria_topic_7#c_ABG_Pharyngeal-diphtheria_topic_7

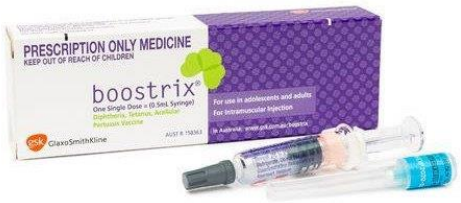
8. Western Australia Department of Health . WA diphtheria outbreak case and contact management interim guidance. Accessed on 29/04/2026 from https://www.health.wa.gov.au/~/media/Corp/Documents/Health-for/Infectious-disease/diphtheria/WA-diphtheria-outbreak-case-and-contact-management-interim-guidance.pdf

Appendix 1 – Contact tracing sheet

Please use only if live spreadsheet not accessible.

Index Case Details **Name:** **DOB:**					**Diphtheria Type:**			**Toxigenic:**		**Date of contact tracing:**		
Date of contact	Address (if compound specify house number)	First Name	Surname	DOB	Risk cat: High Medium Low	Swabbed: Yes No Refused	Antibiotic type, dose duration	Vaccine name Yes No Refused	Batch Number	Factsheet Yes No	Vaccinators Name	Last diphtheria containing vaccine

Appendix 2 – dTpa Vaccination Cheat Sheet

Brand	Age group	
Adacel	≥10 years of age as booster	
ADT	≥ 5 years of age as booster	
Boostrix	≥ 4 years of age as booster Pregnancy	
Infanrix hexa	Infants and children ≥ 6 weeks of age primary immunization Booster dose in children ≥ 18 months	

Appendix 3 – AHCWA resources for contact tracing

How to protect yourself and your community

when you've been around someone with diphtheria

High-Risk Contact

- Watch for a **sore throat or any skin sores** for the next 7 days. See your clinic quick if you get a sore throat or skin sores.
- Your clinic might ask to do a **nose and throat swab** to check for diphtheria – the results can take a few days to a week or so to come back.
- Take **antibiotics** each day for 5 days as instructed by your clinic – this helps to stop you getting diphtheria and stops you passing it onto others.
- Have a booster diphtheria **vaccine** at your clinic. The clinic will check when you last had one, and give you a booster if you haven't had it in the last year – this helps protect you from getting diphtheria in the future.
- Stay away from babies, sick or frail people, and old people until you have finished at least 3 days of antibiotics or your swab test comes back negative. This might mean not going to school, childcare, or work if you work with vulnerable people.

If you have questions, call your clinic (Ph: _____)
or the local public health unit (Ph:_____)

You can also call Healthdirect Australia on 1800 022 222

How to protect yourself and your community

when you've been around someone with diphtheria

Medium-Risk Contact

- Watch for a **sore throat or any skin sores** for the next 7 days. See your clinic quick if you get a sore throat or skin sores.
- Take **antibiotics** each day for 5 days as instructed by your clinic –this helps to stop you getting diphtheria and stops you passing it onto others.
- Have a booster diphtheria **vaccine** at your clinic. The clinic will check when you last had one, and give you a booster if you haven't had it in the last year – this helps protect you from getting diphtheria in the future.
- Stay away from babies, sick or frail people, and old people until you have finished at least 3 days of antibiotics. This might mean not going to school, childcare, or work if you work with vulnerable people.

If you have questions, call your clinic (Ph: _____)
or the local public health unit (Ph:_____)

You can also call Healthdirect Australia on 1800 022 222

How to protect yourself and your community

when you've been around someone with diphtheria

Low-Risk Contact

- Watch for a **sore throat or any skin sores** for the next 7 days. See your clinic quick if you get a sore throat or skin sores.
- Have a booster diphtheria **vaccine** at your clinic. The clinic will check when you last had one, and give you a booster if you haven't had it in the five years – this helps protect you from getting diphtheria in the future.

If you have questions, call your clinic (Ph: _____)
or the local public health unit (Ph:_____)

You can also call Healthdirect Australia on 1800 022 222