HEALTH ADVISORY

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Summary and Action Items

1.) Illinois has recorded its first measles case in 2026. Details about exposure locations are listed below.
2.) 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 and to take appropriate steps for diagnosis and infection control and isolation to prevent transmission to the public.
3.) Clinicians as well as community members should review vaccination records prior to international or domestic travel to assess risk of measles exposure and get recommended vaccinations.
4.) 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 confirmed Illinois' first case of measles in 2026. The individual is an adult from the Metro-East area with unknown vaccination status. They were considered infectious during February 5th-13th, 2026. IDPH is working closely with the local health department to identify individuals exposed and to monitor exposed people who had no history of vaccination or prior disease. Federal partners are assisting with notifications related to exposures that occurred during a cruise and flight. Below is a list of reported exposure locations in Illinois, including dates and times of potential exposure:

Exposure Location	Address	Dates/Times of Exposure
St. Louis Lambert Airport, Terminal 2	St. Louis, Missouri	2/7/2026 from 5 PM to 7 PM
Good Shepard Lutheran Church	1300 Beltline Road, Collinsville, Illinois	2/8/2026 from 8 AM to 12:15PM

As of February 13, 2026, the CDC reports 910 confirmed measles cases in the US in 2026 from 24 jurisdictions. There have been 5 new outbreaks reported in 2026, and 90% of confirmed cases (822 of 910) are outbreak-associated (62 from outbreaks in 2026 and 760 from outbreaks that started in 2025).

Globally, measles outbreaks are occurring; therefore, unvaccinated travelers are at an increased risk, and we are seeking to make providers aware of the steps to take to prevent and manage measles.

Diagnosis

Clinicians and health care facilities should be alert for possible measles cases, especially in people who could have traveled to the above exposure locations or other areas where cases are occurring. Clinicians should review the clinician mini-toolkit to guide decisions on testing. The measles prodrome usually lasts for two to four days but may persist for as long as eight days. Symptoms typically include fever and malaise, followed by conjunctivitis, coryza (rhinorrhea), and cough. The prodromal symptoms typically intensify a few days before the rash appears. The measles rash is typically maculopapular and starts on the head or hairline and spreads down the body. Clinicians should be suspicious in those that are ill and had recent travel internationally or to areas of the U.S. where there is an ongoing measles outbreak.

If you suspect measles, immediately place the patient in airborne isolation, and notify infection control or your facility's point person for measles response. Notification to the local health

department is outlined below. Non-immune (see below in Vaccination section for definition of measles immunity) contacts of measles cases can be vaccinated within three days (72 hours) of exposure, or in some special situations given immune globulin (IG) within six days of exposure to prevent or ameliorate the illness. Clinicians should administer a second MMR dose to contacts over 12 months of age who were previously vaccinated with only one dose, as long as there are 28 or more days since the last dose of live vaccine.

Reporting

Clinicians and health care facilities need to immediately (and no later than within 3 hours) report suspect measles cases to their local health department or to IDPH. **This means reporting at earliest clinical suspicion and at the point testing is requested; 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 which then delays a response if the case is positive (see instructions for submission). Swabs should be placed in viral transport media (VTM).

Serum can be tested by commercial laboratories for measles-specific IgM antibodies. Clinicians should obtain both a serum sample and a respiratory specimen (throat swab or nasopharyngeal swab) from patients suspected of having measles.

See the measles testing flowchart in the IDPH Clinician Measles Mini-Toolkit.

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 of their diagnosis in advance.

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 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 (see below for definition of measles immunity) contacts of measles cases can be vaccinated within three days (72 hours) of exposure (if over six months of age and no contraindications to vaccination), or in some special situations given immune globulin within six days of exposure to prevent or ameliorate the illness.

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.
    - Clinicians may consider accelerated dosing for children 12 months and older by administering the second dose at least 28 days after the first dose without waiting until the child turns 4 years old.
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 regularly scheduled 2 MMR doses at 12 months of age and older.
        - 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

Target Audience: Healthcare Providers, Hospital Infection Preventionists, Emergency Departments, Local Health Departments

Date Issued

February 17, 2026