National Federation of State
High School Associations

Sports Related Skin Infections
Position Statement and Guidelines

National Federation of State High School Association (NFHS)
Sports Medicine Advisory Committee (SMAC)

Skin-related infections in both the community setting and the sports environment have increased considerably over the past several years. While the majority of these infections are transmitted through skin-to-skin contact, a significant number are due to shared equipment, towels, or poor hygiene in general. The NFHS Sports Medicine Advisory Committee (SMAC) has put forth general guidelines for the prevention of the spread of theses diseases (See NFHS General Guidelines for Sports Hygiene, Skin Infections and Communicable Diseases).

The NFHS SMAC recognizes that even if these guidelines are strictly adhered to, skin infections will continue to occur given the nature of certain sports. For example, the risk of transmission is much higher in sports with a great deal of direct skin-to-skin contact such as football and wrestling. Therefore, the NFHS SMAC has developed specific guidelines for the skin infections most commonly encountered in sports. The guidelines set forth follow the principles of Universal Precautions and err in favor of protecting participants in situations where skin-to-skin contact may occur. Consideration may be given to the particular sport regarding risk of transmission, but these rules must be strictly adhered to in sports such as wrestling, football, and basketball where skin to skin contact is frequent and unavoidable.

Ringworm, Tinea Corporis

These fungal lesions are due to dermatophytes. As they are easily transmissible the athlete should be treated with an oral or topical antifungal medication for a minimum of 72 hours prior to participation. Once the lesion is considered to be no longer contagious it may be covered with a bio occlusive dressing.

Impetigo, Folliculitis, Carbuncle and Furuncle

While these infections may be secondary to a variety of bacteria, they should all be treated as Methicillin-Resistant Staphylcoccus aureus (MRSA) infections. The athlete should be removed from practices and competition and treated with oral antibiotics. Return to contact practices and competition may occur after 72 hours of treatment providing the infection is resolving.

All lesions are considered infectious until each one has a well-adherent scab without any drainage or weeping fluids. Once a lesion is no longer considered infectious, it should be covered with a bio occlusive dressing until complete resolution. Since nasal colonization of these bacteria is common, treatment with intranasal topical mupirocin should be considered for recurrent episodes.

All team members should be carefully screened for similar infections. If multiple athletes are infected, consideration should be given to obtaining nasal cultures of all teammates. This can identify carriers and allow for targeted treatment with intranasal mupirocin and daily body washes with a chlorhexidine 4% solution for at least five days.

Shingles, Cold Sores

These are viral infections which are transmitted by skin-to-skin contact. Lesions on exposed areas of skin that are not covered by clothing, uniform, or equipment require the player to be withdrawn from any activity that may result in direct skin-to-skin contact with another participant. Covering infectious lesions with an occlussive dressing is not acceptable. Primary outbreaks of shingles and cold sores require 10-14 days of oral antiviral medications while recurrent outbreaks require five days of treatment as a minimum treatment time prior to returning to participation. To be considered “non-contagious,” all lesions must be scabbed over with no oozing or discharge and no new lesions should have occurred in the preceding 48 hours.

Herpes Gladiatorum

This skin infection, primarily seen among wrestlers, is caused by Herpes Simplex Virus Type 1 (HSV-1). The spreading of this virus is strictly skin-to-skin with the preponderance of the outbreaks developing on the head, face and neck, reflecting the typical lock-up position. The initial outbreak is characterized by a raised rash with groupings of 6-10 vesicles (blisters). The skin findings are accompanied by sore throat, fever, malaise and swollen cervical lymph nodes. The infected individual should be removed from contact and treated with antiviral medications. They may return to contact only after all lesions are healed with well adherent scabs, no new vesicle formation and no swollen lymph nodes near the affected area. Consideration should be given to prophylactic oral antivirals for the remainder of the season and each subsequent season.

Recurrent outbreaks usually involve a smaller area of skin, milder systemic illness and a shorter duration of symptoms. Treatment should include oral antivirals. If antiviral therapy is initiated, the participant must be held from wrestling for five days and there should be no swollen lymph nodes near the affected area. If antivirals are not used, the infected participant may return to contact only after all lesions are well healed with well adhered scabs, no new vesicle formation, and no swollen lymph nodes near the affected area. Even greater consideration should be given to prophylactic antivirals for the remainder

of the current season and each subsequent season when a wrestler has suffered a recurrent outbreak.

As the HSV-1 may spread prior to vesicle formation, anyone in contact with the infected individual during the three days prior to the outbreak must be isolated from any contact activity for eight days and be examined daily for suspicious skin lesions. To be considered “non-contagious,” all lesions must be scabbed over with no oozing or discharge and no new lesions should have occurred in the preceding 48 hours.

Miscellaneous Viral Infections

Molluscum contagiosum and verruca are types of warts that are caused by viruses, but are not considered highly contagious. Therefore these lesions require no treatment or restrictions, but should be covered if prone to bleeding when abraded.

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