Back-to-School Task Force Recommendations

July 24, 2020 – original recommendations published

Updated July 23, 2021

Updated August 1, 2022

Introduction

Le Bonheur Children's Hospital and the University of Tennessee Health Science Center (UTHSC) have been providing guidance to school leaders to keep children safe during the ongoing COVID-19 pandemic. The situation continues to evolve in 2022 with a majority of students and staff now having some level of protection against severe infection with the SARS-CoV2 virus (the cause of COVID-19) through vaccination, previous infection or both. Our goal remains unchanged: to provide guidance to minimize risks of illness and absenteeism for students, parents, teachers and staff. Pediatric experts at Le Bonheur and UTHSC provide care to the region's children to improve their health and overall well-being.

We want children to thrive, and it is clear that the last two years of this pandemic have led to significant learning loss from which schoolchildren are still recovering. The overarching goal of this guidance remains the provision of practical advice for implementing local, state and national guidance on keeping children learning safely in school during the pandemic while balancing risk of illness in children, staff and families.

We are updating this guidance again in 2022, considering changing levels of immunity within the community and the emergence of variants of SARS-CoV-2 causing reinfection among previously vaccinated and infected individuals. In-person learning is the rule in most schools and making up for learning losses and continuing to move forward is critical. There will continue to be changes to this document over time, as guidance from professional and governmental organizations changes and will be updated as new scientific evidence becomes available.

We know there will be questions that are not addressed in this document as we cannot anticipate all potential problems. We continue to learn and adapt to this pandemic as reflected by the changes to the document. Le Bonheur and UTHSC are committed to being available to provide counsel to schools and parents on COVID-19 and other topics. Questions submitted from schools will shape future versions of this document as schools and parents experience the realities of school opening.

As we move through this pandemic, our world is slowly returning to what we consider "normal." However, many experts continue to say that our post-COVID-19 world will never be the same as the pre-COVID-19 world. In addition, we continue to face new additional infections we have not previously encountered, like Monkeypox. We will address these threats as they arise and provide the best guidance we can as we know it.

Important changes to this document in 2022 are:

1. Continued strong encouragement for up-to-date vaccination (three doses for most) of all eligible students, faculty and staff including those who have previously experienced COVID-19 infection.

2. Masking is encouraged for anyone who wants or needs that extra layer of protection, including for those with high-risk conditions or who have family members with high-risk conditions. We recommend that masking be implemented during periods of high community transmission by CDC's COVID-19 community level tracker (https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html#county-check).

3. CDC is no longer recommending contact tracing and quarantining of individuals who have been exposed to COVID-19. Students and staff who have been exposed to someone with COVID-19 should wear a mask around others for 10 days after the last exposure regardless of vaccination status or previous infection (i.e. this is the same for everyone). Schools should notify individuals if they have had an exposure in the school and require mask wearing. Some schools may choose not to enforce masking among contacts of COVID-19.

4. CDC has not changed their recommendations for isolation of individuals with COVID-19 except for recommendations around use of rapid antigen testing to shorten isolation. Thus schools should continue require students with consistent symptoms to be tested for COVID-19 before returning to school. Note that rapid antigen tests may be negative at the onset of symptoms and should be repeated in 1-2 days.

    a. After a positive test, individuals must isolate at home for 5 days. On days 6-10, if symptoms are improving and the individual is without fever for 24 hours or more, the individual can return to school wearing a mask (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html). Rapid antigen testing can be used to shorten the duration of masking. Individuals who have negative tests on two consecutive days with the first on or after day 6 can discontinue mask wearing. Everyone can stop mask wearing after day 10 regardless of test result i.e. a negative test is not required after day 10 to stop wearing a mask.

    b. Some schools may choose to manage COVID-19 illness in the same manner as yearly influenza epidemics and other respiratory viruses. By this we mean that children who are ill are sent home and remain home until fever free for 24 hours and feeling better but return to school after that without masking. This would reduce the number of missed days of school; however, if infections increase, which is likely with the highly transmissible BA.4 and BA.5 subvariants of SARS-CoV-2 omicron variant, there will likely be a great many infections introduced into school from home and acquisition of infections in the school setting. Most infections will be mild or asymptomatic, but this could result in widespread absenteeism as was seen during the 2009 H1N1 influenza pandemic. In this case, schools may choose not to require testing and isolation for COVID-19 infections and masking for exposures.

    c. The strategies adopted by schools may change with changing rates of transmission in the community. A school may choose to be more relaxed in policies during periods of low transmission and adopt stricter rules during periods of high transmission. Currently (second week of August 2022), transmission in Shelby county is low but many other counties nearby have moderate or high transmission.

5. There is no current requirement for schools to report cases to the Health Department. This may change if schools or districts are seeing very high transmission rates.

Table of Contents

Recommendations for Policies on Infection Prevention and Medical Policies and Procedures

This document provides specific recommendations for schools to implement recommendations from the Centers for Disease Control (CDC), Tennessee Department of Health (TDH), and Shelby County Health Department (SCHD).

Section 1 – Vaccination against COVID-19

- The best way to keep children in school and learning with all the social, educational, nutritional, and mental health benefits that accompany full-time attendance in school is through vaccination.

- Children should be up-to-date on all recommended vaccines

- Children, faculty, and staff who are eligible (anyone 6 months of age and older) should be up-to-date on COVID-19 vaccine. This means that you have received the required primary dose (Johnson&Johnson) or doses (Pfizer or Moderna) and that one has received recommended boosters (1 additional dose of Pfizer after Pfizer or Johnson & Johnson). A fourth dose of vaccine has been recommended for those over 50 years. In fall 2022, we are expecting release of another dose that includes both the original vaccine and one modified to protect against the current circulating omicron subvariants BA.4 and BA.5.

- Yearly influenza (flu) immunization is also strongly recommended for everyone six months of age and older as we expect both influenza and SARS-CoV-2 to be present in the community this winter.

Section 2 – Entering school and screening

- Screening of children and staff for symptoms of COVID-19 and/or temperature checks before entering the school building is not recommended.

- Anyone who has new symptoms that could be consistent with COVID-19 (see list below) should stay home and be tested. This includes students, faculty and staff.

    - New or worsening cough
    - Shortness of breath/difficulty breathing
    - New loss of taste or smell
    - Fever (temperature of 100.4°F or greater) or feeling feverish
    - Sore throat
    - Muscle aches and pains
    - Headache
    - Nasal congestion/runny nose
    - Nausea/vomiting/diarrhea/abdominal pain

- Caregivers should keep a child at home if he or she has any of these symptoms. Requirement for COVID-19 testing is determined by the school and the family can choose to test the child. The child should stay home while acutely ill (1-2 days) and must be fever free for 24 hours at a minimum before returning to school.

- Schools may choose to continue to use the algorithm in the appendix to determine if testing for COVID-19 is required based on the number and type of symptoms.

- Anyone who is a close contact, household contact or within six feet for more than 15 minutes (three feet in the school setting), of a known COVID-19 case should wear a well-fitted mask when around others for 10 days following exposure if vaccinated or recently infected (in last 90 days).

- If COVID-19 community transmission increases to a high level per CDC guidelines, it is recommended that everyone wear masks to limit spread of virus and limit absenteeism. As of August 8, 2022, Shelby County has a LOW rate of community transmission but many other counties in Tennessee have moderate or high transmission rates. https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html?msclkid=c6264aabb43011ec9f1814ab7fe7520a

- Isolation and return to school rules following illness are found in Section 7.

Section 3 – Sick children or staff members

- Children and adults in schools may begin to feel ill at any time of day. Teachers and other staff should be watchful of students and refer students to the school nurse or other designated staff member if a child complains of feeling sick or appears unwell.

- Schools may have a dedicated space that functions as a sick room for anyone in school who is displaying signs or symptoms (see Section 6 and Appendix A) of COVID-19 and other infections.

- The COVID-19 sick room should be separate from the well child room (or space) used for administering medications or doing procedures on well students. Schools may use a divider for this purpose, but separate rooms would be optimal.

- Ill students or staff may be requested to wear a mask even if there is a contraindication (see Section 5).

- The ill individuals should leave the school as soon as possible and not return until allowed by the school depending on the school rules. Any siblings of the ill child may also be asked to leave if displaying any signs or symptoms. Asymptomatic siblings can stay in school, with or without a mask, depending on the school.

- Students and staff should stay at home if ill, regardless of vaccination status. This should be reinforced frequently with families.

Section 4 – Protection for school nurses, educators and staff members

- Nurses or other staff attending to ill individuals who may have COVID-19 should wear a well-fitted mask (or may wear an N-95 mask) and eye protection.

- Face shields may be cleaned with an approved disinfecting wipe. If caring for multiple sick individuals at the same time, the nurse or designated individual may keep his or her mask and face shield in place and change gowns (if there is sufficient supply) and gloves between patients.

- Minimize aerosol-generating procedures in schools. The only aerosol-generating procedure that is likely to occur in school is airway suctioning (tracheostomy care).

- For these procedures, nurses or other designated individuals should don N-95 masks, face shields, gloves, and gowns.

Section 5 – Masks, physical distancing and screening testing

- Although not required by the state of Tennessee, masking is recommended by the CDC for anyone who desires or needs the extra layer of protection. Physical distancing of three feet between individuals is desirable but not required. Spacing helps limit the number of children counted as exposed if there is a case of COVID-19.

- During periods of high community transmission (https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html?msclkid=c6264aabb43011ec9f1814ab7fe7520a) schools may require masking of everyone in their buildings.

- Children with disabilities who need constant, frequent, close presence of a teacher or helper should be considered individually. This is addressed in the guidance in the Special Medical, Educational, and Behavioral Needs section below.

- Any person who has symptoms suggestive of COVID, including those with a mask exemption, should wear or have a mask placed on him or her as soon as symptoms are recognized. Those with exemptions should be monitored closely and have the mask removed if the person cannot tolerate the mask. If moving such a person through the school, hallways should be cleared of as many people as possible and keep people not directly attending to the person at least six feet away. All staff members should be wearing masks in this case.

    - It is recommended that schools require masking for an individual who has had close contact with a person with COVID-19 who has symptoms (in the period from two days before symptom onset until they meet criteria for discontinuing home isolation; can be laboratory-confirmed or a clinically compatible illness)
    - a person who has tested positive for COVID-19 (laboratory-confirmed) but has not had any symptoms (in the two days before the date of specimen collection until they meet criteria for discontinuing home isolation)
    - If a child is near another child who has COVID-19 in school, the child is not considered an exposure if both children are properly wearing masks.

Section 6 – Protocol for ill child or adult in school

- There is a long list of signs and symptoms that are associated with COVID-19. Some of these symptoms have become more common with variants of SARS-CoV-2 including congestion and sore throat and these may be the only signs and symptoms among individuals who have some immunity already.

    - High-risk symptoms for COVID (those that are common and relatively specific for COVID) include:
        - **fever**
        - **cough**
        - **shortness of breath/increased work of breathing**
        - **loss of sense of taste or smell**

    - Low-risk symptoms for COVID (those that are more common and alone do not necessarily indicate COVID-19) include:
        - **sore throat**
        - **nasal congestion/nasal discharge**
        - **nausea/vomiting/diarrhea**
        - **myalgias (muscle aches)**
        - **headache**
        - **fatigue**

- **Any child or adult with one high-risk or two low-risk** criteria (any one of the first group or any two of the second group of symptoms) should be considered to have a "COVID-like illness" and be isolated in a sick room until he or she can leave the building. He or she should wear a mask at all times.

- **Any child or adult with only one low-risk** symptom is considered less likely to have COVID and should be sent home. These individuals will be able to return after 24 hours if they are feeling better and no further symptoms develop.

- Contacts (child or adult) of a suspected or known case of COVID-19 do not need to quarantine but should wear masks for 10 days after exposure. Some schools may not require masking of contacts.

- In the **K–12 indoor classroom** setting, the close contact definition ***excludes* students** who were within **3 to 6 feet of an infected student** (laboratory-confirmed or a clinically compatible illness) where both students were engaged in **consistent and correct use of well-fitting masks.** This does not apply to exposures between adults and children or two adults or outside of schools.

- Schools may inform families of COVID-19 exposures using phone, email or text. Individuals who are identified as contacts of a possible case should be asked to wear a mask in school for 10 days from the date of exposure.

Section 7 – Protocol for isolation and return to school for cases and contacts

Definitions

Isolation: the 10-day period during which an individual with COVID-19 must stay away from others to prevent the spread of infection. Isolation starts at the time of onset of symptoms or, if asymptomatic, on the day of a positive test. Isolation continues for a minimum of 10 days. If symptoms are improving and the individual is afebrile for at least 24 hours he/she can come out of isolation after five days but must wear a mask around others for an additional five days.

- Note that isolation should start at the onset of symptoms. You should not wait for a positive test to begin isolating.

- Schools should not require a negative rapid antigen test for return to school after 10 days (or five days with masking). Children can return to school on day 6 wearing a mask if they are feeling better and without fever for more than 24 hours. Individuals can stop wearing a mask before the end of the 10 day isolation period if they have 2 consecutive negative rapid antigens tests with the first occurring on day 6.

Quarantine: CDC is no longer recommending home quarantine for individuals exposed to COVID-19. Individuals with an exposure can continue to be in the school building but should wear a mask when around others for 10 days.

- Anyone with an illness that is unlikely to be COVID (single low-risk symptom resolving in 24-48 hours or non-infectious diagnosis such as migraine, allergies) may return to school when symptoms have improved or he or she has a negative test.
    - This person does not need to see a physician or be tested to be cleared to return to school. If symptoms do not resolve quickly or this person is a contact of a known case of COVID-19, the individual should be assessed by a physician and considered for testing.

- Anyone with a COVID-like illness (one high-risk or two or more low-risk symptoms) should be assessed by a physician and tested for COVID (as well as influenza, RSV, group A *Streptococcus* depending on the signs and symptoms).
    - If the test is negative, or another cause of illness (pathogen) is identified, and the person is not a contact of a COVID case, then he or she can return to school when symptoms have improved and afebrile for ≥ 24 hours.
    - If the test is positive or no test is done (and no other cause of illness or pathogen is identified), this person must isolate for COVID-19.
    - Isolation should begin as soon as symptoms are recognized and should not be delayed for testing or awaiting results.
    - Anyone who is a contact of a known case of COVID must be quarantined at home or wear a well-fitted mask (if the school chooses) for 10 days from the date of last potential exposure to the COVID case. If this person develops symptoms during quarantine, he or she should then start isolation unless he or she has a negative test, in which case the quarantine period continues

- Anyone who has not been exposed to a COVID case and is asymptomatic should not be tested except as a part of a routine screening program.

Section 8 – School sports

Post-COVID Return to Play Screening of Athletes

- Tennessee Secondary School Athletic Association (TSSAA) requires clearance by primary care physician/pediatrician before returning to play (https://tssaa.org/returntoplay).

- Post-COVID return to participation screening should include a general medical evaluation by a pediatrician or other licensed medical provider with a focus on cardiac symptoms, including but not limited to chest pain, shortness of breath, fatigue, palpitations or loss of consciousness.

- Those with moderate or severe COVID symptoms should be referred to pediatric cardiology for detailed cardiovascular screening prior to returning to play or exercise.

    - Mild symptoms are considered above the neck and GI symptoms (cough, runny nose, nasal congestion, headache, loss of smell and taste, diarrhea).

    - Moderate symptoms are considered below the neck (shortness of breath). We do not recommend cardiovascular screening by a cardiologist for asymptomatic or mild symptoms. This is true in adults and children.

- All individuals with a history of a positive test result for SARS-CoV-2 should have a gradual return to physical activity. Post-illness and quarantine/isolation protocols, most will be starting at a pre-season level of conditioning. This stage in sports is intended to get the body moving and ready to compete.

    - Adjust activity level to around 30-50% of the athlete's pre-COVID activity level. This should include training frequency, intensity, volume and repetitions.

    - Weeks 1-2 should focus on low to moderate intensity: light jogging, skill training, and bodyweight exercises.

    - Athletes may adjust or increase workload by about 10-20% per week.

    - Frequent return to exercise reports of burning in the chest, shortness of breath, muscle cramping, dizziness, severe fatigue and slow recovery from exercise.

Section 9 – School supplies, communal equipment (including balls, jump ropes, and playground equipment), and physical environment

- Use of shared objects should be minimized, although transmission from shared objects and surfaces is very uncommon. Other respiratory viruses are more likely to spread by contact e.g. rhinoviruses (common cold).

- Playgrounds should be treated like gyms with frequent cleaning of equipment. Children should wash or sanitize hands before and after use of playground equipment.

- Other high-touch surfaces (door handles, faucets) should be frequently cleaned and disinfected on a set schedule developed by the school.

Make sure that EPA-approved cleaning and disinfecting products are stored safely and used correctly. These should not be used when children and staff are around without ensuring adequate ventilation.

Section 10 - Hand hygiene

- All individuals must wash and/or sanitize their hands frequently. It is reasonable to perform hand hygiene upon entering and leaving the classroom, after touching high-touch surfaces like door handles, and before eating meals or snacks.

- Handwashing for at least 20 seconds with soap and water should be done for soiled hands, hands that have been sneezed or coughed into, or after using the restroom and before eating.

Section 11 – Riding the bus

- School buses should be frequently cleaned and disinfected.

Section 12 - Appropriate restroom etiquette

- Children should sanitize hands when leaving the classroom and wash hands with soap and water after using the restroom and sanitize hands when re-entering the classroom.

Section 13 – Influenza vaccine and other childhood vaccines

- Influenza vaccine for all children should be strongly recommended. Reducing influenza transmission will keep more children in school, make identification of COVID easier clinically and reduce demand for testing.

- Opt-in or preferably opt-out administration of influenza vaccine in schools would be beneficial.

- During the last two years of the pandemic, many children have missed important well-child appointments, including those for regular childhood immunizations. Schools should encourage families to have children seen by a physician or other practitioner and get caught up on missed doses of recommended vaccines.

Recommendations for Policies and Procedures for Children with Special Medical, Educational and Behavioral Needs

Section 1 – Health-Medical Needs

- Individual Health Plans (IHP) may need to be updated with additional precautions for the most vulnerable students. Parents can be encouraged to contact the child's health care provider for specific guidance if the child has a serious medical problem. Teachers, nurses and other staff members should be especially vigilant to prevent the spread in children with chronic serious health conditions. Try to reduce the number of individuals involved in the care of an individual child, when possible, to limit exposure.

- Students with significant disabilities may have more difficulty in telling caregivers when they don't feel well. Specific symptoms such as sore throat, "feeling bad" or loss of taste/smell may be especially difficult for a child with developmental delays/disabilities to describe. Teachers and staff should remain alert for changes in behavior, appetite, sleepiness, or other signs that may indicate early symptoms of illness. Cough, difficulty breathing and fever should be judged as one would for any child. See Infection Control protocols for action steps.

- More staff may be needed. Increased nursing support may be needed to address COVID-related issues in addition to the usual medical concerns of those with special health needs.

- Children with special health needs may be more likely to be absent from in-person school if they are ill. Be prepared and convey to parents that it may be necessary to pivot to virtual options, if available.
    - Medication and supplies that may be kept at school may be needed at home. Contingency plans may be helpful to allow for pick up or maintain duplicate supplies.

- Consider how changes in the physical environment and new patterns of distancing may adversely affect students with limited mobility. Consider how they will get to new locations with new protocols for space use.

- Sensory deficits (reduced hearing and/or vision) may limit understanding of instructions, thus, new COVID-related procedure information will need to be provided in multiple formats.

- In medical settings, we typically think of procedures such as tracheal suctioning as likely to create more airborne spread of respiratory droplets (often associated with cough). Thus, additional personal protective equipment (PPE) is recommended for school-based personnel. See Section 4 above for details "Protection for school nurses, educators and staff members." Procedures such as tube feedings aren't likely to increase respiratory droplets, though closer proximity to the child is needed to administer these.

Section 2 – Developmental/Special Educational Needs

- It will be important to review Individual Education Plans /Programs (IEPs) and Section 504 Plans for each child and involve parents in decision-making. We recommend frequent communication with parents about options. After changes including reduced or different formal instruction, children who may not have needed extra help or special education services before the pandemic may benefit from those interventions now. Please request evaluation for a possible disability if there are concerns about a child's learning.

- Federal disability law allows for flexibility in determining how to meet the individual needs of students with disabilities.
- IEP teams make an individualized determination on services for each child. Specific instructional or alternate methodologies are not mandated. Parents, educators and administrators are encouraged to collaborate creatively to continue to meet the needs of students with disabilities.
- Schools should provide information on availability of special education services. For information on the rights of students with disabilities and schools' obligations, please refer to information provided by the Department's Office of Special Education and Rehabilitative Services and Office for Civil Rights. COVID-19 resources are available from the U.S. Department of Education (https://www.ed.gov/Coronavirus).

- Younger children and those with developmental delays/disabilities will need information on COVID-related procedures targeted to their level of understanding. Additional staff may be necessary to ensure safety protocols are followed.

- Emphasis on repetition of routines and reinforcement will help for desired behaviors such as mask compliance, hand washing, distancing, etc. Encourage practice at home.

- Some children, especially those with significant disabilities, may have difficulty in complying with certain preventive strategies (such as mask use) or find it difficult to maintain physical distancing. Strategies to address their individual needs should be considered. For example, children who are unable to maintain distancing would benefit from masking, and vice versa. See Section 5 above – Masks, physical distancing, and screening testing.

- Plan for increased soiling, damage and loss of face masks for children with special needs. We recommend the schools have extra masks available in variety of sizes if possible. If masks are too large, think creatively about ways to adjust strap size for smaller children (for ear loop type).

- Student who are deaf and hard of hearing:
    - Face masks with clear plastic cut-outs so the lips may be seen are an acceptable alternative to face masks. A clear plastic face shield alone is not considered adequate protection from airborne respiratory droplets.

- Similarly, children with vision loss/blindness will need instruction that addresses their needs for hands-on materials.

- Children with certain developmental disabilities may be more likely to have behavioral responses that increase the risk of spread of infection. See also Section 3 – Mental Health/Behavioral.

Section 3 – Mental Health/Behavioral

- Most brief crying episodes won't likely be significant enough to produce extra respiratory droplets. It is best for the child's mask to remain on to reduce spread of respiratory droplets. It remains important for social distancing to be maintained as much as possible. The teacher's face mask should remain on and the teacher may consider a face shield or goggles if a child's behavior outburst is especially intense. See Section 5 – Masks, physical distancing, and screening testing.

- Otherwise, such behaviors are recommended to be handled by usual procedure. Each situation will vary, and each school may have different available space and personnel to handle. If at all possible, consider plans for managing behavioral issues in advance, especially if a child has a behavior plan incorporated into an IEP.

- Provide a normal routine when possible. Predictability is important.
    - Increased teachers/staff absenteeism and/or turnover may be stressful for kids. Plans for having some familiar people, especially for younger kids will be helpful.

- Social (physical) distance is not social isolation – give kids a chance to interact, but in a safe way. When classroom-based education is not possible, consider techniques that optimize social interactions alongside educational objectives.

- Allow time for students to verbalize feelings with the school's counselor, teacher, or nurse. Understand that a public health crisis may create significant trauma to children. Mindfulness exercises may be helpful. Give kids time to process and relax during the day.

- Children and families with the following ongoing other sources of stress or trauma will be at extra risk (and will also likely have fewer resources) among others:
    - Highly mobile families
    - Foster care
    - Homelessness and other socioeconomic concerns
    - Families who speak languages other than English
    - No transportation
    - Inconsistent communication contacts
    - Communities in which COVID-related illness and death have occurred at high rates
    - Communities of color

- With new stressors, children who may not have exhibited emotional issues in the past may now need extra help.

- Keep communication lines open school to home and vice-versa.

- School staff may be an important safety net for students to seek assistance for home concerns. Particular attention should be paid to noticing signs of abuse or neglect.

- Identify ways to provide counseling and non-academic supports to students and staff, as needed. Have non-school resources for well-being and mental health to which they may refer families in need.

- More kids are experiencing behavior problems and mental health concerns since the pandemic began. It is important to look for signs a child may not be coping well and ask for help from the school counselor, an outside counselor or doctor.

Conclusion and Communication

Parents and schools will continue to need reliable, trustworthy information. The Le Bonheur and UTHSC Back-to-School Task Force members are committed to continuing to be partners with schools and to assist with useful content for parents, children and educators.

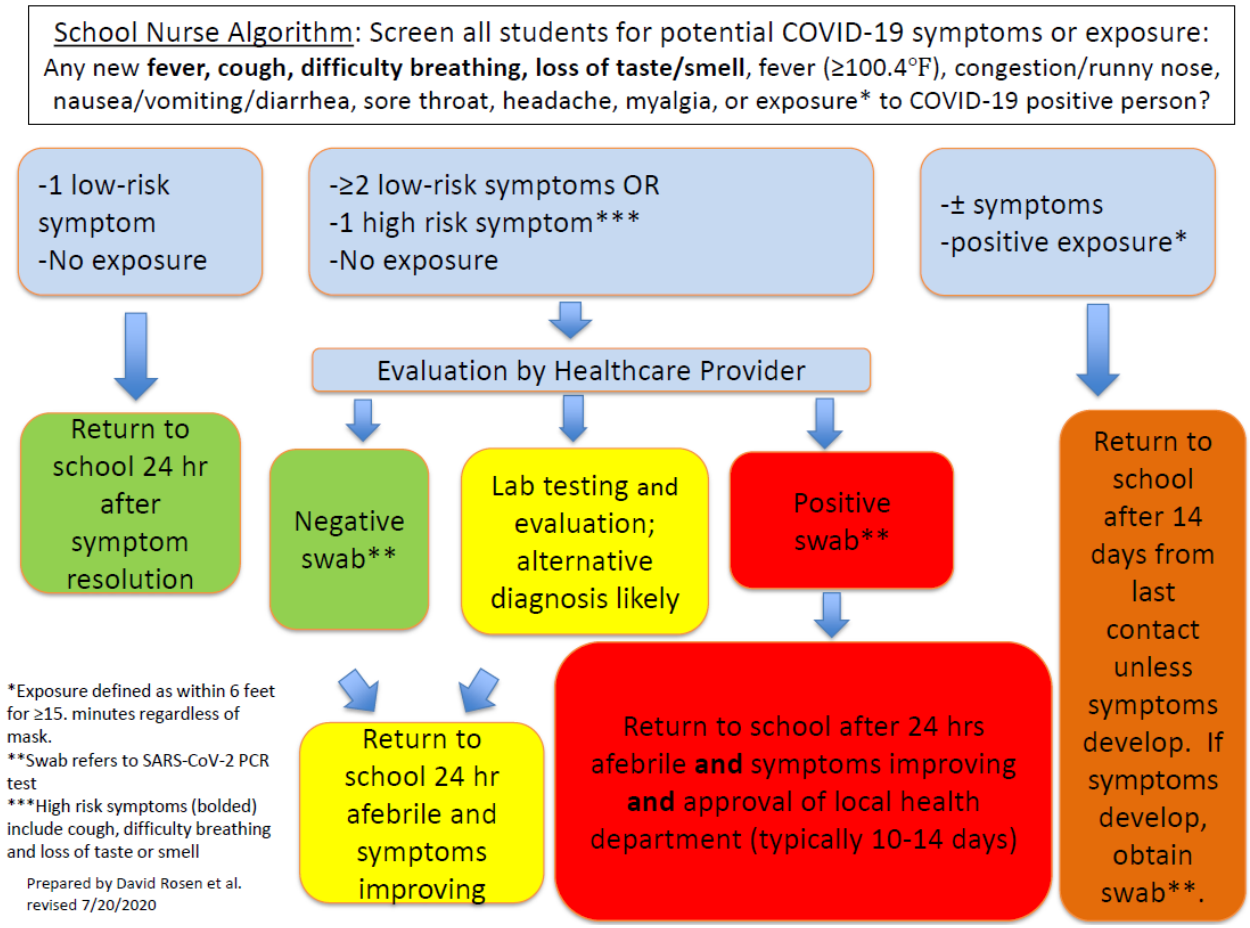
Available content includes information on normalizing mask wearing, vaccines, testing and screening, among others. Continued feedback from schools and parents will help inform what information is desired.

For more information, including tool kits and protocol updates, visit www.lebonheur.org/coronavirus and www.uthsc.edu/coronavirus.

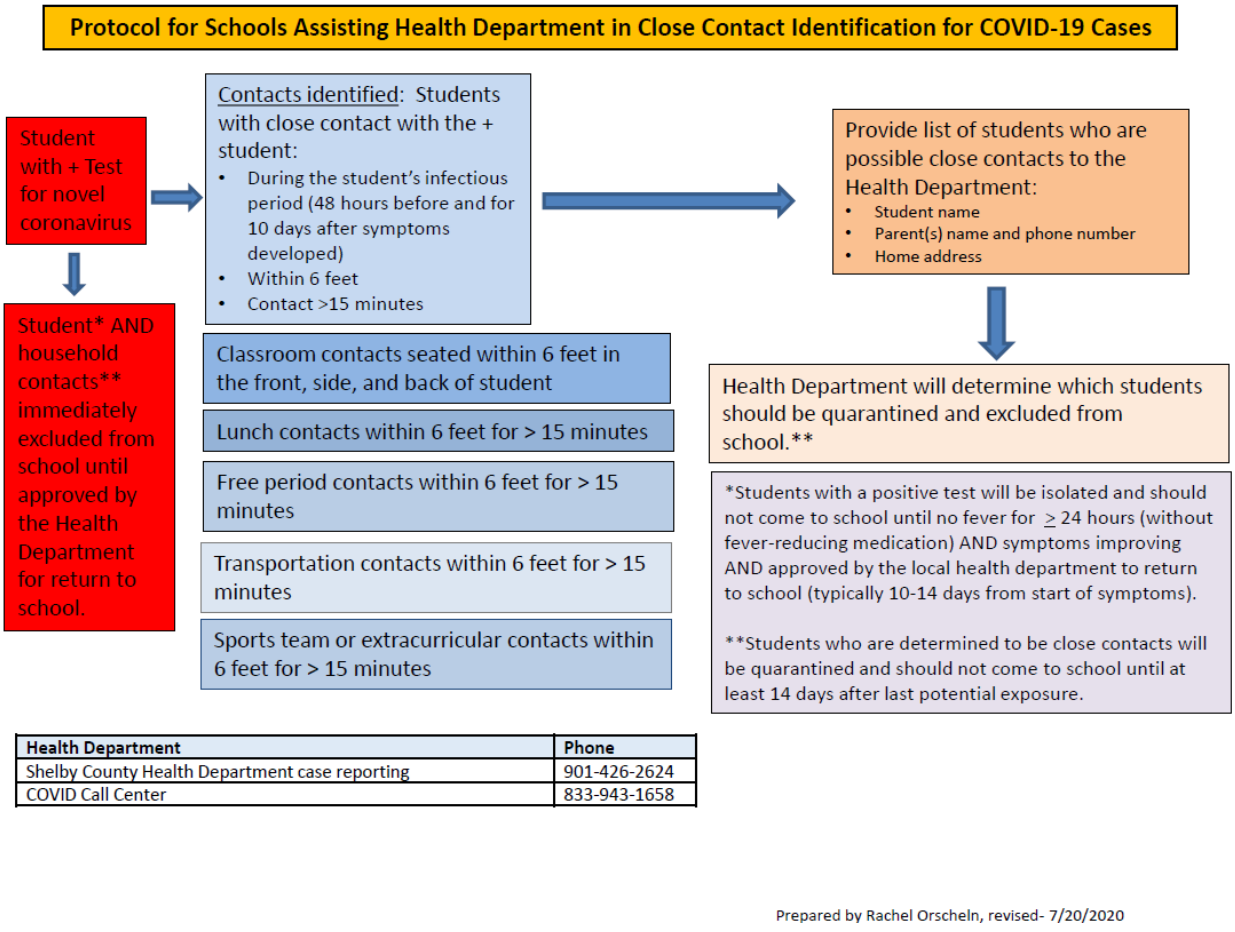
The Task Force is committed to being a resource for schools and is preparing to shift the model from crisis response to a permanent resource for schools and parents. Schools, parents and administrators are invited to continue to submit questions or topics they would like addressed.

Appendices

Appendix A


School Nurse Algorithm: Screen all students for potential COVID-19 symptoms or exposure:
Any new fever, cough, difficulty breathing, loss of taste/smell, fever (≥100.4°F), congestion/runny nose, nausea/vomiting/diarrhea, sore throat, headache, myalgia, or exposure* to COVID-19 positive person?
-1 low-risk symptom
-No exposure
-≥2 low-risk symptoms OR
-1 high risk symptom***
-No exposure
-± symptoms
-positive exposure*
Evaluation by Healthcare Provider
Return to school 24 hr after symptom resolution
Negative swab**
Lab testing and evaluation; alternative diagnosis likely
Positive swab**
Return to school after 14 days from last contact unless symptoms develop. If symptoms develop, obtain swab**.
Return to school 24 hr afebrile and symptoms improving
Return to school after 24 hrs afebrile and symptoms improving and approval of local health department (typically 10-14 days)
*Exposure defined as within 6 feet for ≥15. minutes regardless of mask.
**Swab refers to SARS-CoV-2 PCR test
***High risk symptoms (bolded) include cough, difficulty breathing and loss of taste or smell
Prepared by David Rosen et al.
revised 7/20/2020

Appendix B



Health Department	Phone
Shelby County Health Department case reporting	901-426-2624
COVID Call Center	833-943-1658

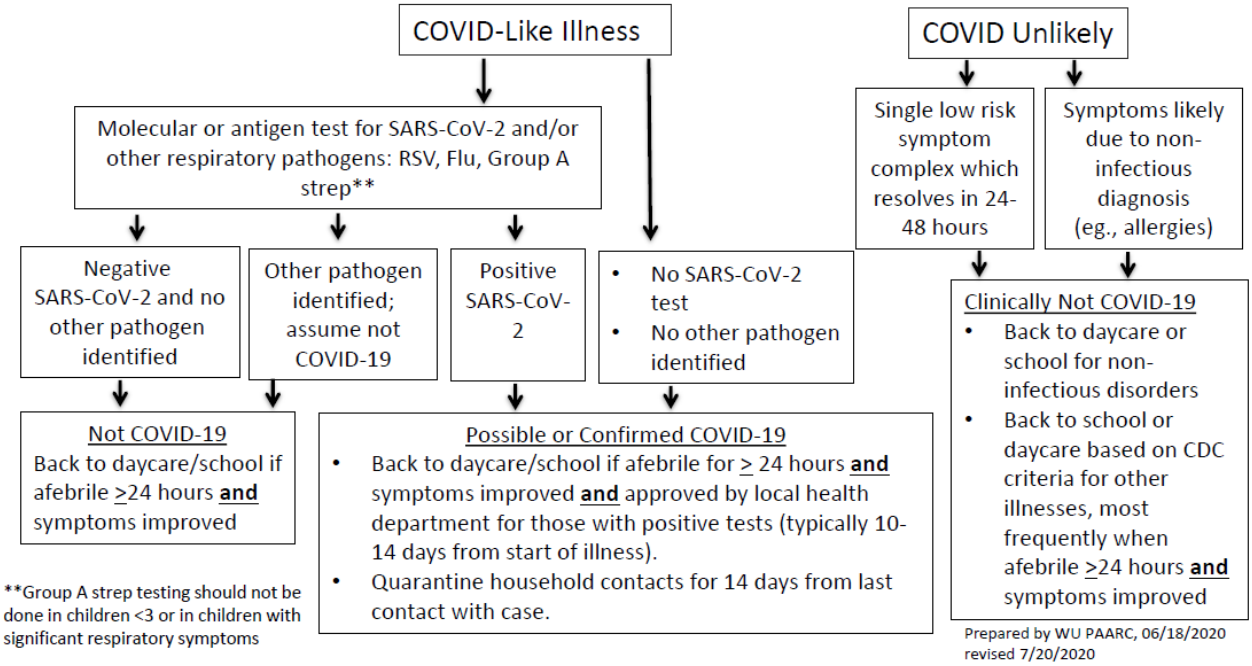
Prepared by Rachel Orscheln, revised- 7/20/2020

Appendix C

<u>Assessing for COVID-19 in children with symptoms of illness & no known exposure:</u> Consider SARS-CoV-2 for the patients with a single high-risk symptom or 2 or more low risk symptoms (note: symptoms grouped together are considered a single symptom).

High Risk*	Low Risk
❑ Fever/chills/rigors ❑ Cough ❑ Shortness of breath or difficulty breathing ❑ New loss of taste or smell	❑ Headache ❑ Myalgias ❑ Sore throat ❑ Runny nose/congestion ❑ Nausea/vomiting/diarrhea

*High risk symptom based on specificity, seriousness, or risk for spread of SARS-CoV-2. **Clinicians may elect to test with one low risk symptom due to high clinical suspicion and/or testing readily available.**



**Group A strep testing should not be done in children <3 or in children with significant respiratory symptoms

Prepared by WU PAARC, 06/18/2020 revised 7/20/2020

Appendix D

CDC's COVID-19 Community Levels

[1] **CDC's COVID-19 Community Levels and Indicators** NAAT – nucleic acid amplification test (for example, PCR). Excludes rapid antigen tests.

New Cases (per 100,000 population in the last 7 days)	**Indicators**	**Low**	**Medium**	**High**
Fewer than 200	New COVID-19 admissions per 100,000 population (7-day total)	<10.0	10.0-19.9	≥20.0
	Percent of staffed inpatient beds occupied by COVID-19 patients (7-day average)	<10.0%	10.0-14.9%	≥15.0%
200 or more	New COVID-19 admissions per 100,000 population (7-day total)	NA	<10.0	≥10.0
	Percent of staffed inpatient beds occupied by COVID-19 patients (7-day average)	NA	<10.0%	≥10.0%

The COVID-19 community level is determined by the higher of the inpatient beds and new admissions indicators, based on the current level of new cases per 100,000 population in the past 7 days

Children with Special Medical, Educational and Behavioral Needs Sub-Committee Members

Toni Whitaker, MD – Division Chief, Developmental Pediatrics
Danielle Keeton – Director of Outpatient Rehab and Developmental Services
Tim Flack -- Senior Attorney, Memphis CHILD Medical Legal Partnership
Phil Norfolk, PhD -- Psychologist
Angelica Eddington, PhD -- Pediatric Psychologist
Kathryn McCaa Bryan -- Program Officer, The Urban Child Institute
Webb Smith, PhD – Exercise Physiologist
Brittany Schwaigert – Le Bonheur Family Partner Council member

Infection Prevention Sub-Committee

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Jennifer Berger, MD – Pediatrician, Memphis Pediatrics
Catherine Chidester, MD – Pediatrician, Yukon Clinic
Kenice Ferguson-Paul, MD – Infectious Disease physician
Nick Hysmith, MD – Medical Director, Infection Prevention
Karen Lakin, MD – Medical Director, CARES child abuse team
Jason Yaun, MD – Division Chief, Outpatient Pediatrics

Medical Policies and Procedures Sub-Committee

Cynthia Cross, MD – Division Chief, Pediatric Hospital Medicine
Charnece Brown, RN – School Health
Eric Ellerbrook – Dyersburg City Schools
Patrick Galphin – Le Bonheur Family Partner Council
Cindy Hogg, RN – Director, School Health
Sandra Madubuonwu, PhD – Maternal Child
Arwa Nada, MD – Nephrologist
Chelcie Oseni, RN – School Health
Terrie Whitfield, RN – Community Nursing
Sherrie Yarbro – Tipton County Schools
Toni Whitaker, MD – Division Chief, Developmental Pediatrics

Communication Sub-Committee

Sara Burnett – Le Bonheur Public and Community Relations
Mary McDonald, EdD – Educator and Le Bonheur National Leadership Council
Samantha Alperin, EdD – Christian Brothers University professor and Family Partner Council member
Butler Bernard – student volunteer
Alan Burns – UTHSC Communications
Jackie Denton – UTHSC Communications
Annie Eber – Le Bonheur Marketing
Cedrick Gray, EdD – Shelby County Director of Education
David Henson – Le Bonheur Public and Community Relations
Haley Hysmith – communication volunteer
Jessica Liles – Director, Child Life
Stephania McCain – educator and Family Partner Council member
Nellann Mettee – Le Bonheur Communications

Chelcie Oseni, RN – Le Bonheur School Health
Sara Patterson – Le Bonheur Digital Communication
Alize Prather – Le Bonheur Public and Community Relations
Webb Smith, PhD – exercise physiologist
Andrew Sullivan – Le Bonheur Audio Video Services
Meg Webb – Le Bonheur Brand and Marketing
Katherine Whitfield, MDiv – Le Bonheur Volunteer and Family Support
Toni Whitaker, MD – Division Chief, Developmental Pediatrics