

## **Back-to-School Task Force Recommendations**

**July 24, 2020**

### **Introduction**

Le Bonheur Children's Hospital and the University of Tennessee Health Science Center (UTHSC) have developed guidance to provide school leaders regarding reopening schools and to parents educating their children virtually during the COVID-19 pandemic. Our hope is that this guidance will minimize risks of illness to 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 are concerned that their overall well-being will be eroded by loss of educational, social, therapeutic and nutritional necessities provided by schools. Our overarching goal with this guidance is to provide practical advice for implementation of local, state and national guidance on how to most safely return kids to in-person school. We cannot eliminate risk, but we can reduce it. We also want to provide guidance and support for families who choose to educate their children virtually.

The advice provided in these pages will change in time, as guidance from professional and governmental organizations changes and will be updated as new evidence becomes available.

We know there will be questions that are not addressed in this document as we are in uncharted territory. We will continue to be available to answer questions as they arise and provide counsel to schools and parents. The questions will shape future versions of this document as schools and parents experience the realities of school opening with our children.

All the requirements set forth in this document are meant to provide children, teachers and staff with an environment that promotes safe practices for being in the classroom, moving about the school and during activities and limiting the amount of SARS CoV-2 in the air.

We all want things to go back to normal and for children to be able to take advantage of all learning, co-curricular and extra-curricular activities that schools have to offer. But we all must accept that in order for everyone in our community – both within and outside schools – to stay healthy, major modifications to the school day must occur. Not everything will be as we want it to be, and we will have to accept "good enough" for many months to come. This guidance will be modified based on the level of community transmission with restrictions lessened if transmission becomes lower over time.

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## **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 – Entering school and screening**

- The TDH and CDC currently recommend daily symptom (and temperature if possible) screening by families in their homes prior to school each day.
- The Tennessee Department of Health suggests the following symptoms are potentially COVID-19 symptoms and should apply to anyone attending or working in a school (i.e. children and adults in schools):
  - New, 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
- Families can also check their children’s temperatures at home. Parents should keep their child at home if he or she has any of these symptoms. If a child is behaving as though he or she does not feel well or feels feverish (feels cold, staying under blankets, shivering) or hot to the touch, the child should be kept home.
- If a child has any of the higher-risk symptoms (fever/feverishness, cough, shortness of breath or loss of taste/smell or has two or more of the other symptoms) the child should be seen by his or her health care provider (see Section 5). These children should be tested for COVID-19 if possible.
- If a child has only one of the lower-risk symptoms (sore throat, headache, muscle aches, headache, congestion or gastrointestinal symptoms) then he or she should be kept home for observation for other symptoms. The siblings of a child with high-risk symptoms should be kept home until it is determined if the child has COVID-19.
- Anyone who is a close contact (household contact or within 6 feet for  $\geq 15$  minutes) of a known COVID-19 case should stay home for 14 days.
- Isolation and return to school rules following illness are found in Section 7.
- Should COVID-19 community transmission drop to and remain at a lower level, the need for testing and exclusion for these symptoms will be reassessed.

## **Section 2 – 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.
- School should assign dedicated space that functions as a sick room for anyone in school who is displaying signs or symptoms (see Section 5 and Appendix A) of COVID-19, including fever.
- The COVID-19 sick room should be separate from the well 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.
- Any ill student or staff should immediately have a mask put on even if there is a contraindication (see Section 4).
- The ill individuals should leave the school as soon as possible. Based on the symptoms present (one high-risk or two or more low-risk symptoms, see Section 5), the ill individual should call his or her primary care provider and be tested for COVID.
- A communication packet with a clear message to parents at the beginning of school year should be provided to families outlining the expectations for picking up their children should they be ill at any time during the school day.
- Plan for a child to be picked up within one hour. If there are siblings of the ill child in school, siblings will be dismissed as well.
- Encourage two or three emergency contacts with updated phone numbers to be provided for each family in case the parent cannot answer the phone or leave work. Avoid having a high-risk individual (someone who is at risk for severe COVID if infected e.g. grandparent older than 65 years) pick up the child if possible. The person picking up the child must wear a mask in the school and is strongly recommended to wear the mask in the car.
- Students and staff should stay at home if ill. This should be reinforced frequently with families.

### **Section 3 – Protection for school nurses, educators and staff members**

- Nurses or other staff attending to ill individuals who may have COVID should wear an N-95 mask, face shield, gown and gloves. Schools will have to provide this personal protective equipment.
- **N-95 masks** may be reused unless visibly soiled and should be placed in a paper bag between uses.
- **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 most common aerosol generating procedure is use of nebulized medications for asthma. Nebulizers should only be used as a last resort. Families should obtain MDIs/spacers for children with asthma in place of nebulizers. Most school-aged children should be able to use a spacer. The only other aerosol-generating procedure that is likely to occur in school is airway suctioning (e.g. tracheostomy care).
- For these procedures, nurses or other designated individuals should don N-95 masks, face shields, gloves and gown. Aerosol-generating procedures should preferably be done outdoors where possible in a private place to maintain confidentiality of the student.
- If not able to be done outdoors, these aerosol-generating procedures may be done in the sick room; however, this room must left unoccupied after the procedure with the door closed for three hours (assuming only two air exchanges per hour). If a portable HEPA air filtering unit can be placed in the room then the duration of time before it can be used again may be reduced to one hour.

## **Section 4 – Masks and social distancing**

- Masking and physical distancing are required to keep children healthy and in school.
- **Masks should be worn every day as much as possible by students and staff, with the exception of individuals who have a medical exemption for masking for behavioral or medical reasons.** Physical distancing of children who cannot wear masks is very important to prevent exposure. Parents should notify staff and administration of these students in advance of the start of school.
- Children with disabilities who need constant, frequent, close presence of a teacher or helper should be considered individually. This is addressed in the guidance from the Special Medical, Educational and Behavioral Needs Sub-Committee below.
- If a person with a mask exemption has symptoms suggestive of COVID, a mask should be placed on this person, and the person 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 6 feet away. All staff members should be wearing masks.
- School-aged children should wear a cloth mask (or if preferred, a neck gaiter), but some will struggle with it more than others. Schools must be prepared to supply cloth or surgical style masks with ear loops to children upon entry (if they don't have one, or if masks become soiled or wet). Children should not be turned away if they present to school without a mask, but should be provided one. Perhaps appeals to community volunteers to sew child-size masks or make donations for families to purchase masks would help with this. Parents should be advised to have their children practice wearing masks while at home and going about normal activities to get acclimated to wearing it all day.
- Mask breaks should preferably be done outside and/or when 6 feet of separation from others can be assured. Children can remove masks to eat and drink.
- Teachers should wear masks and could use those with a clear plastic cut out in the center for young children or children who have hearing loss to be able to see their mouths when they speak. An alternative to this style of mask would be a face shield that fits closely on the sides with a hood or drape to prevent escape of aerosols beneath the shield.
- Masks will cause no harm to children when they are sitting still or exercising. Masks should not be removed for sneezing and coughing. Spare masks should be provided if a mask becomes wet from sneezing or coughing.
- Masking will not be considered as protective in contact tracing triggered by a COVID case in the school. Exposure will be defined by distance and duration of exposure only (see bullet below).
- Physical distancing of 6 feet between individuals (between students, and between students and teachers) in classrooms, and other locations around the school, is recommended based on recommendations from CDC, TDH and the Shelby County Health Department. The current definition of an exposure to COVID from CDC is:
- An individual who has had close contact (< 6 feet) for ≥15 minutes 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)
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- Physical distancing should be maintained as much as possible, including outdoors. Smaller distances between individuals for prolonged periods of time (such as in the classroom) will require more students to require prolonged isolation at home should a case occur in the school.
  - Plexiglas barriers may be used to reduce exposure to aerosols in certain situations where it is not possible to maintain 6 feet of separation. These can be used in the cafeteria to separate workers from each other and students, or in restrooms between sinks to provide separation. Using Plexiglas around student desks might help reduce the spread of infection; however, in a classroom, aerosols and droplets will come from the sides as well as the front and back of the child so protection will be incomplete.
  - Students should spend as little time as possible in areas where students may be in close proximity to others, such as hallways. Hallways may be made one way only so that students are not bumping into each other or, where that is not feasible due to the size or layout of the school, two way with students staying to the right. This will require monitoring by staff and signs in the hallway to make sure that this being done properly. Staggered start times may help alleviate congestion in the hallways.

## **Section 5 – Protocol for ill child or adult in school**

- There is a long list of signs and symptoms that are associated with COVID-19 including:
  - 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 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 have a mask on at all times and anyone entering the isolation room should wear full personal protective equipment (PPE) – i.e. an N-95 mask and face shield, as well as a gown and gloves.
- **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. One exception to this is young children with nasal discharge, which is very common in the young school-aged child. Children younger than 10 are less likely to be symptomatically infected and less likely to transmit virus to others.
- Any sibling of a child identified as having a COVID-like illness will be required to leave the school as well and isolate at home until it is determined if the ill child has COVID.
- Any child or adult (including all family members) with a known or possible COVID contact and with any one symptom in the high- or low-risk category should be seen by a physician and should have a COVID test if possible; however, when testing is not easily available, it is reasonable to assume an ill individual with a known contact has COVID and notify the Health Department.
- Parents should notify the Health Department immediately if someone in their household (adults and school-aged children) has a positive test. Ill teachers or staff should do the same. The school should also notify the Health Department of confirmed COVID infection. The numbers to call are:
  - Shelby County – (901) 426-2624 or COVID Call Center (833) 943-1658
  - Crittenden County Health Department – (870) 732-3764
  - Tipton County Health Department – (901) 476-0235
  - Fayette County Health Department – (901) 465-5243



- Desoto County Health Department – (662) 429-9814
- Arkansas Department of Health COVID-19 Call Center – (800) 803-7847
- Arkansas Department of Health – (800) 462-0599
- Mississippi COVID Hotline (Seven days a week, 7am-7pm) – (877) 978-6453
  - Hard of Hearing? Dial 711 for assistance

See Appendices A for algorithms for handling ill children and staff.

## **Section 6 – Process to handle a COVID case in school**

- COVID cases should immediately be reported to the local Health Department using the numbers above. Families and schools should report cases directly to their local Health Department.
- Positive test results will also be reported by the laboratory, physicians’ office or testing site performing the test as well. The Health Department officials will help administrators determine a course of action for their child care programs or schools. Schools should also be prepared with a list of the possible contacts of the cases in the school identified by contact tracing (see below). The Health Department will ultimately determine which contacts require home isolation. See Section 5 for COVID exposure, isolation and return to school guidance.
- Names of COVID cases and contacts should not be released to anyone but the Health Department. Families of students should be informed about the presence of the COVID case(s) in the school, but individuals should not be named. Those deemed to be contacts should also be given information about remaining in isolation at home for 14 days. The Health Department will contact families of cases and contacts as well for contact tracing and to provide them with information on what to do.
- The school and/or district should identify someone to monitor absences and return to school dates, possibly School Nurse and/or Attendance Officer.
- Schools will need to be prepared to help perform contact tracing when there is a COVID case in the school. While the Health Department usually performs this function, school officials and teachers are in the best position to determine which individuals had significant contact with the infected individual and require isolation. A plan outlining who will help with contact tracing (one or more individuals) and how this will be carried out should be made ahead of time.
- Appendix C has guidance for how to conduct contact tracing in the school. Contact tracers should determine through interviews with students and teachers which individuals spent more than 15 minutes within 6 feet of the infected individual, starting two days before onset of symptoms. Enforcing physical distancing will make contact tracing much easier. Individuals wearing full PPE (i.e. school nurse with gown, gloves, N-95 mask and face shield) will not be considered contacts regardless of distance and duration of exposure.
- Individuals who are identified as contacts of a possible case should be excluded from school until the suspected case is confirmed positive or negative. If the suspected case has a negative test, then contacts can return to school.

- The classroom where the exposure took place will be shut down for at least 24 hours for a thorough cleaning. The Health Department may choose to shut the classroom or school for two to five days for cleaning and contact tracing. If the school remains open, the individuals (including entire class) should be rescreened for symptoms and fever. Children who are not considered contacts (were not within six feet for  $\geq 15$  minutes) may be able to stay at school, but contacts will be immediately sent home. If possible, the remaining class members could be moved to a different room while the other classroom is cleaned and ventilated per CDC guidance.
- If a cluster of cases (**two or more cases sharing a common source**) occurs in a school, or if widespread exposures have occurred as a result of an infected teacher or counselor who spent time in multiple locations in the school, then the school will need to be closed to allow for contact tracing and cleaning. This will also be done in consultation with the Health Department.
- Children required to stay at home because of illness and quarantine should have access to online learning during school absences.

See Appendix B for contact tracing algorithm.

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

### Symptomatic children and adults

- Anyone with an illness that is unlikely to be COVID (single low-risk symptom resolving in 24-48 hours or non-infectious diagnosis e.g. migraine, allergies) may return to school when symptoms have improved and afebrile for  $\geq 24$  hours (usual policy for any illness).
  - 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, the individual should be assessed by a physician and considered for testing.
  - If this person is a contact with a known COVID case, then this person should be seen by a physician and tested to determine if he or she can return to school or requires isolation.
- 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 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  $\geq 24$  hours.
  - If the test is positive or no test is done (and no other pathogen identified), this person must stay home for minimum of 10 days and be afebrile with improving symptoms for  $\geq 24$  hours.

### Asymptomatic children and adults

- Anyone who is a contact of a known case of COVID must be isolated at home for 14 days from the date of last potential exposure to the COVID case. If there is ongoing exposure to the case in the household then the date of last potential exposure is 10 days after the onset of symptoms of the COVID case.
  - If this person develops symptoms during this 14-day period, he or she should continue isolation for 10 days beyond the day of onset of symptoms and have improving symptoms for  $\geq 24$  hours and no fever.

- If anyone in the household develops symptoms of COVID during the 14-day isolation period, then the start date of the isolation period resets to the first day of symptoms for that contact and must continue for 10 days after that exposure (see section on symptomatic with likely COVID).
- If this person remains asymptomatic during this 14-day period, testing for COVID is not recommended as the best timing for such a test is unknown and a negative test would not shorten the period of isolation.
- Anyone who has not been exposed to a COVID case and is asymptomatic should not be tested.

Students and staff need clearance from the Health Department, but not from a physician, to return to school when the isolation period has ended. A school official should monitor absences and dates of isolation to approve return.

See Appendix C for algorithm for return to school.

## **Section 8 – School sports**

- Returning to school sports depends on the degree of physical distancing possible and the level of transmission of COVID in the community. Currently, Tennessee contact sports (including fall sports – football, girls' soccer as well as others such as lacrosse, wrestling, cheerleading, etc.) are limited to strength training and conditioning only per the governor's most recent executive order.
- Contact sports should remain suspended as long as there is widespread virus transmission in the region. Individual and non-contact sports such as tennis, golf or track where 6 feet of distance can be maintained should be able to continue. Full participation in contact sports (games between schools) during a period of high COVID transmission puts players at high risk for exposure.
- If a player on either team was diagnosed with COVID, many, if not all, players who had been on the field or court, could be required to isolate at home for 14 days because of lack of physical distance and masking in a situation where individuals are shouting and breathing heavily.

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

- Children should not share school supplies. There should be no communal writing or art utensils that cannot be cleaned between uses.
- Classes should have dedicated play equipment as much as possible, and these items should be cleaned to the extent possible between uses by different children. These items should be cleaned at the end of playtime to be ready for their next use. Classroom and physical education teachers should plan outdoor activities for children that limit contact such as running games, calisthenics, etc.
- Playgrounds should be treated like gyms. Equipment should be cleaned before and after use by a single classroom group or cohort. Sections of a playground should be blocked from use to maintain social distancing while using equipment. Children should wash or sanitize hands before and after use of playground equipment.
- Physical distancing during outdoor play should be enforced and monitored. Masks may be removed outside if physical distancing can be maintained. More than one staff member will likely be needed to monitor distancing and hygiene when playing.

## **Section 10 – Participation in band, orchestra or choir**

- We have seen strong evidence that singing produces high quantities of large and small droplets. Singing in groups indoors will promote the spread of COVID and should be suspended unless it is possible for individuals to be placed 6 feet apart in a single row. This may work with smaller choral groups of six to eight people. Those facing the singers (conductor or audience) would have to be 18 feet away from the singers. Rehearsing outdoors is one possible solution to provide sufficient space for this activity.

- Band instruments (brass and woodwind) also produce aerosols that can spread COVID-19 in differing amounts based on the instrument (straight instruments expel greater amount of aerosol than instruments with bends). Cloth coverings over the openings of instruments can reduce the amount of aerosol expelled and may be safe with 6 feet of social distancing in all directions.
- String instruments do not involve expelling air and should be safe with masking and physical distancing of 6 feet.

## **Section 11 - Hand hygiene**

- All individuals must wash and/or sanitize 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.

## **Section 12 – Riding the bus**

- Encourage parents to bring children to school, if possible, to increase space for physical distancing on buses. All children and bus driver must wear masks. Children should be 6 feet apart in all directions (e.g. alternating rows and sides of the bus and sitting next to windows). Children in the same family can share a seat. Everyone should use hand sanitizer when entering and leaving the bus.
- If there is a case on a bus then the student should be quarantined if he or she was within 6 feet of the case for more than 15 minutes, even if wearing a mask.

## **Section 13 – Eating at school**

- Children should maintain physical distancing while eating regardless of location. Children are encouraged to bring their own lunch when possible.
- School meals should be pre-packaged, grab-and-go meals as much as possible with 6 feet of physical distancing maintained when waiting in line (preferably marked out on the floor). There should not be communal self-service food. If food is being served individually in the cafeteria there should be plastic or glass barriers between the students, and the food/service staff. Only use disposable plates, utensils and service pieces.
- Students can eat in the cafeteria, classrooms or outdoors as long as physical distancing is maintained and monitored.
- Snack breaks should be taken in the classroom.
- Children should wash or sanitize hands before touching food after removing their masks and then again after replacing their masks.

## **Section 14 - Appropriate restroom etiquette**

- Stalls will provide adequate separation in restrooms. Alternate urinals should be used in boys' restrooms and for physical distancing.
- Only as many children as there are stalls (or urinals – counting alternating urinals) should be allowed in the restroom at any time.
- 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. Children should only use sinks that are 6 feet apart (block alternating sinks) or place Plexiglas barriers between sinks.

## **Section 15 – Influenza vaccine**

- Influenza vaccine for all children should be strongly recommended as 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.

## **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 spread with children with chronic serious health conditions. Try to reduce number of individuals involved in 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 actions steps.
- More staff may be needed. Increased nursing support may be needed to address COVID-related issues in addition to 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.
  - 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 physical environment and new patterns may adversely affect students with limited mobility. Consider how they will get to new locations with new protocols for space use.
- Sensory deficits (hearing, 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) should be considered for school-based personnel. If possible to have eye protection (to reduce chance of droplets in the eyes) by a face shield (or goggles) and gown in addition to gloves and medical-grade face masks for such procedures (including N95 masks if available), this would increase safety of the provider.
- Tube feedings, on the other hand, aren't likely to increase respiratory droplets, though closer proximity to the child is needed to administer these. Brief encounters ( $\leq 15$  minutes) closer than 6 feet aren't considered a significant exposure (see also Infection Control guidelines).

## **Section 2 – Developmental/Special Educational Needs**

- It will be important to review IEPs and 504 Plans for each child and involve parents in decision-making. We recommend frequent communication with parents about options.
- Specific guidance available via U.S. Department of Education (supplement 3/2020)
  - Federal disability law allows for flexibility in determining how to meet the individual needs of students with disabilities.
  - IEP teams make an individualized determination whether and to what extent compensatory services may be needed.
  - 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.
- 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.
- For children who can't tolerate certain preventive strategies (such as mask use), alternate strategies should be considered. For children who are not able to wear a mask as recommended, it is especially important for distancing of at least 6 feet to be done at all times. See Infection Control information for additional details.

- 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 solid cloth or medical-grade face masks. A clear plastic face shield alone is not considered adequate protection from airborne respiratory droplets.
  - Videos and streaming that will be required content for students need to be captioned to be accessible.
- 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 Behavioral section.
- Flexibility is encouraged in method and environment for instruction.
  - Encourage parent involvement in home sessions for further reinforcement of learning whenever possible.
  - Encourage parents *and children* to provide feedback on new learning modalities.
  - If more time is needed for new procedures, encourage parent input on what components of typical educational components may be reduced or altered for the individual child.
- Alternate IEP service provision may be considered as available (e.g. telehealth for Speech, OT, PT). Consider partnerships for outpatient clinics. This may offer flexibility in frequency, location and session time. Parent involvement is favored.

### **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 (6 feet or more). 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.
- 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 faces, 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 ongoing other sources of stress or trauma will be at extra risk (and will also likely have fewer resources):
  - Highly mobile families
  - Foster care
  - Homelessness and other socioeconomic concerns
  - Families who speak languages other than English
  - No transportation
  - Inconsistent communication contacts
- 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.

## **Conclusion and Communication**

Parents and schools will continue to need reliable, trustworthy information throughout the school year. The 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.

Content under development includes information on normalizing mask wearing, testing and screening, among others. Feedback from schools and parents will help inform what information is desired throughout the school year.

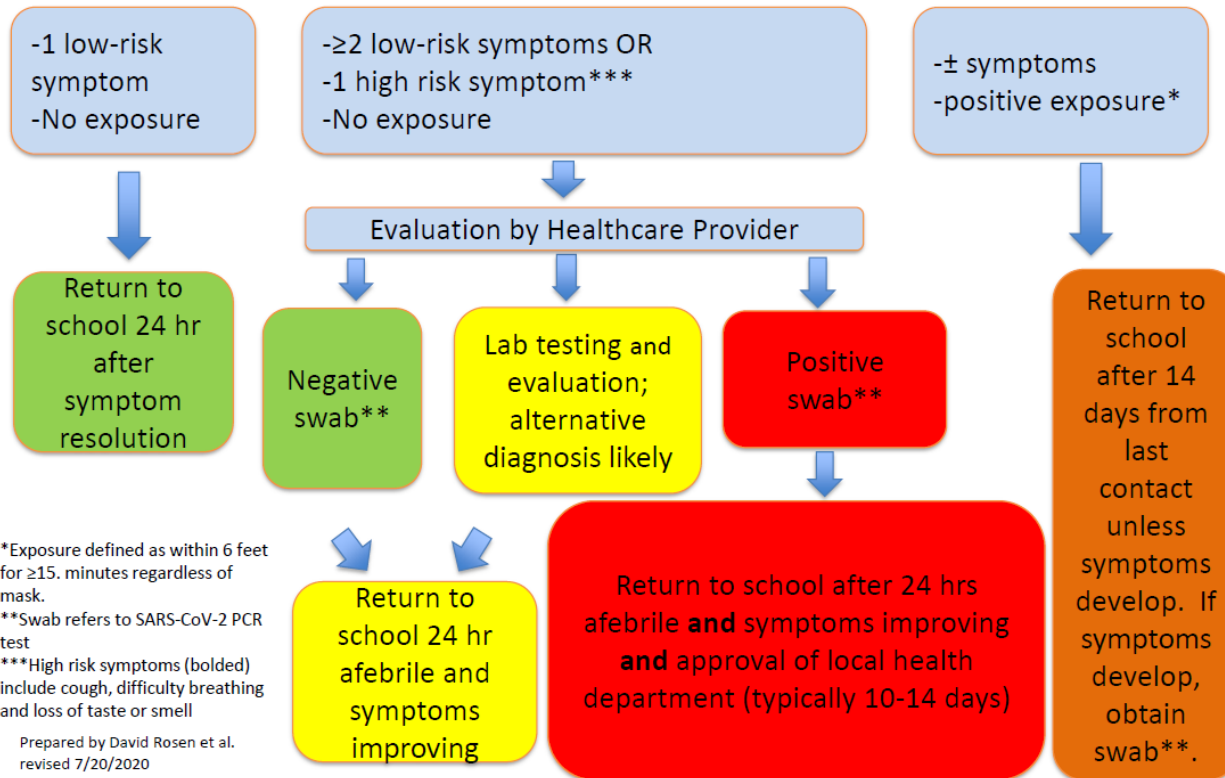
A communication tool kit for schools is under development to assist with protocol information for staff and families.

For more information, including tool kits and protocol updates, visit [www.lebonheur.org/coronavirus](http://www.lebonheur.org/coronavirus) and [www.uthsc.edu/coronavirus](http://www.uthsc.edu/coronavirus).

## Appendices

### Appendix A

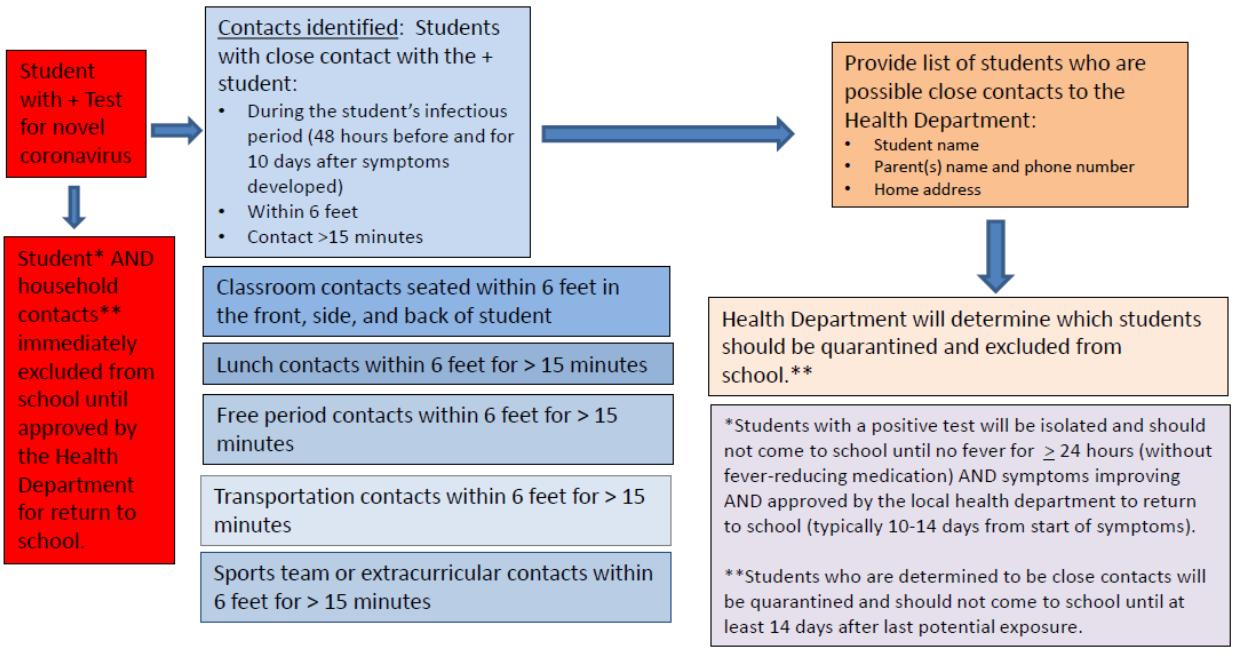
**School Nurse Algorithm:** Screen all students for potential COVID-19 symptoms or exposure: Any new **fever, cough, difficulty breathing, loss of taste/smell**, fever ( $\geq 100.4^{\circ}\text{F}$ ), congestion/runny nose, nausea/vomiting/diarrhea, sore throat, headache, myalgia, or exposure\* to COVID-19 positive person?



\*Exposure defined as within 6 feet for  $\geq 15$  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

## Protocol for Schools Assisting Health Department in Close Contact Identification for COVID-19 Cases



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

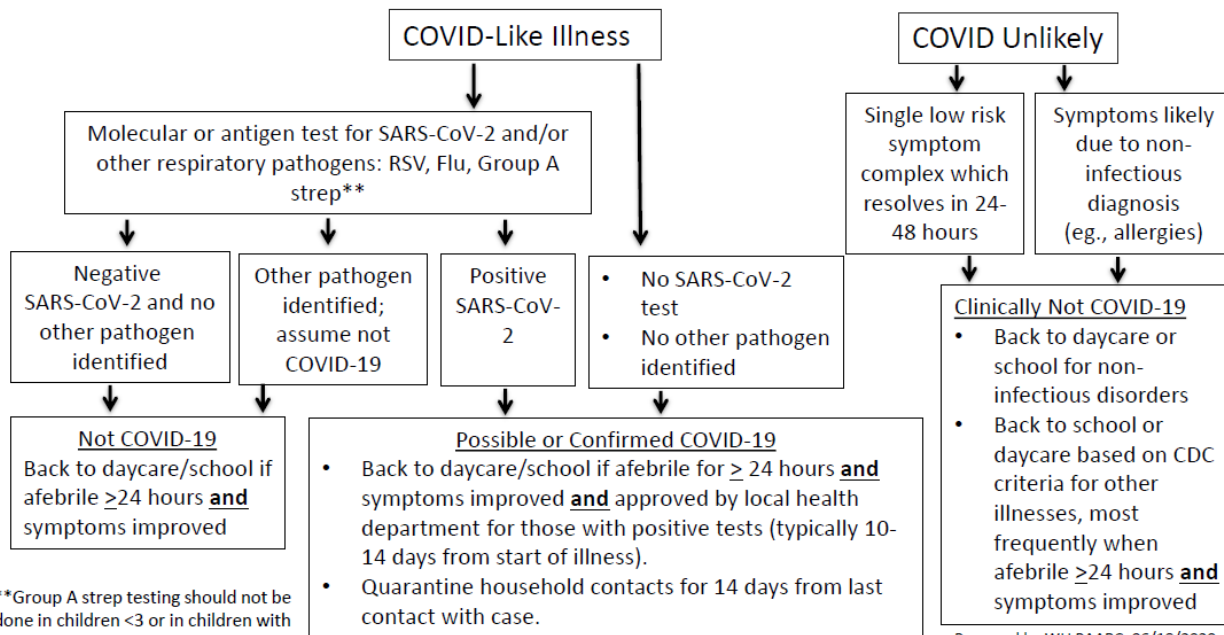
Prepared by Rachel Orscheln, revised- 7/20/2020

## Appendix C

**Assessing for COVID-19 in children with symptoms of illness & no known exposure:** 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 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.

High Risk*	Low Risk
<input type="checkbox"/> Fever/chills/rigors <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath or difficulty breathing <input type="checkbox"/> New loss of taste or smell	<input type="checkbox"/> Headache <input type="checkbox"/> Myalgias <input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose/congestion <input type="checkbox"/> Nausea/vomiting/diarrhea



\*\*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

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