

Back-to-School Task Force Recommendations

July 24, 2020 – original recommendations published

Updated August 2, 2021

Introduction

Le Bonheur Children's Hospital and the University of Tennessee Health Science Center (UTHSC) developed guidance last year to assist school leaders regarding reopening schools during the COVID-19 pandemic. Many things have changed in the past year as we have learned more about the virus, its transmission, and we have vaccines available under emergency use authorization to prevent infection. Our goals remain unchanged: to provide guidance to 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 it is clear that the last year and a half has affected the overall well-being of many children due to the loss of educational, social, therapeutic, and nutritional necessities provided by schools. Our overarching goal of this guidance remains the provision of practical advice for implementing 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.

This guidance has been updated repeatedly since last July as knowledge about COVID-19 has improved. Many schools opened to in-person learning last year, and publications about the experience of these schools have led to changes in the advice provided in these pages. There will continue to be changes to this document overtime, 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 we cannot anticipate all potential problems that will arise. We know much more than we did last year. Thanks to many schools opening, we know that schools can open safely and provide needed educational, social, and nutritional services to our children. 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 transmission of SARS CoV-2.

As much as we all want for things to go back to pre-pandemic normal, it is clear, this many months later that the virus is here to stay. Going forward, we must deal with the virus and its consequences. Our children may still not be able to take advantage of all learning, co-curricular and extracurricular activities that schools have to offer, but they can and should be learning in school. 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 are still going to be in place. Not everything will be as we want it to be, and we will have to continue to accept "good enough" for the time being.

As you can see from watching the news, the Delta variant of SARS-CoV-2 more transmissible and we are seeing younger people becoming seriously ill. Protection from vaccine is still excellent although breakthrough infections are occurring. It is very unlikely that a vaccinated person will require hospital admission, but that person could be infected and spread virus to others. For this reason, we need to continue with other layers of protection (masking, distancing) in and outside of schools even for vaccinated individuals. This virus poses ongoing risk to our communities. This guidance will be modified based on the level of community transmission with restrictions lessened if transmission becomes lower over time.

Important changes to this in 2021 document are:

1. Strong encouragement for vaccination of all eligible students, faculty, and staff. Vaccinated people do not have to quarantine if they are exposed to COVID-19 and do not have symptoms.
2. Masking provides an extra layer of protection to students and faculty. It may be used continuously or be tied to community transmission level. If the infection rate is ≥ 10 cases/100,000 or $\geq 5\%$ of tests positive in the community, then masks should be worn in schools. All unvaccinated adults must wear masks indoors regardless of the level of community transmission.
3. Children should be in school learning. They should be distanced as much as possible from each other to prevent the spread of the virus. Studies of schools in the past year have shown that distances of 3 feet provide similar protection to distances of 6 feet; if a school cannot ensure 3 feet of distance between individuals, other methods such as masking or screening testing should be used to ensure the safety of those in schools.
4. Schools may consider using screening testing at intervals (once or twice a week, random testing, pooled testing) to aid in the prompt identification and isolation of cases to prevent the spread of the virus in schools
5. Information on transmission levels and resources:
 - a. Tennessee Department of Health County Data Snapshot
 - i. <https://www.tn.gov/health/cedep/ncov/data/county-data-snapshot.html>
 - b. Centers for Disease Control and Prevention COVID-19 Integrated County View
 - i. <https://covid.cdc.gov/covid-data-tracker/#county-view>
 - c. Le Bonheur Children's COVID-19 Resource Center
 - i. www.lebonheur.org/coronavirus
 - d. University of Tennessee Health Science Center Coronavirus Information and Resources
 - i. www.uthsc.edu/coronavirus

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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 – 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 who are eligible (currently those who are 12 years of age or older) should be fully vaccinated to optimize safety and learning opportunities for all those attending or working in schools.
- The best way to protect children who are not yet eligible for vaccine is for all vaccine-eligible individuals to be vaccinated.
- All faculty and staff working in schools should be fully vaccinated to optimize safety and learning opportunities for those attending or working in schools.
- The Pfizer BioNTech vaccine currently has Emergency Use Authorization (EUA) for use in all individuals aged 12 years and older and is expected to receive full approval later in 2021. It is expected to be authorized for use in younger children later in 2021 as well. The Moderna and Johnson & Johnson/Janssen vaccines have EUAs for those 18 years and older and are expected to be authorized for younger children later this year.

Hundreds of millions of doses of these vaccines have been given, and they have been proven to be highly safe and effective in the prevention of COVID-19.

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. This includes students, faculty, and staff.
 - 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

- Caregivers should keep a 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 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 either: 1. be kept home for observation for development of other symptoms that would necessitate testing for COVID-19 or 2. be tested for COVID-19. The siblings of a child with high-risk symptoms should be kept home until it is determined if the child has COVID-19 by observation or testing.

- Anyone who is a close contact (household contact or within 6 feet for ≥ 15 minutes) of a known COVID-19 case should quarantine at home for up to 10-14 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. As of July 23, we have high levels of virus transmission in Shelby County.

- Fully vaccinated individuals with signs and symptoms of a COVID-like illness should be kept home and should be tested just like unvaccinated individuals.

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.
- School should assign a 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.
- It would be highly beneficial to students and families to have rapid antigen testing available for children with mild symptoms who would not necessarily need to be excluded from school but for COVID-19. These tests perform well early in infection, so a negative antigen test in a newly symptomatic person would allow the mildly symptomatic child (and siblings) to stay in school.
- 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 the 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. In general, it is recommended that the siblings of the child leave the school as well to quarantine pending testing (or resolution of a single mild symptom); however, if the index child is only mildly ill (one low-risk symptom), the siblings may be allowed to stay in school, masked, if the child is tested the same day. If the child tests positive, then the siblings will have to begin quarantine. Having rapid tests available in schools would reduce the need to exclude siblings when one child in a family develops symptoms.
- 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, for example a 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, regardless of vaccination status. This should be reinforced frequently with families.
- Fully vaccinated individuals with signs and symptoms of a COVID-like illness should be tested and isolate pending testing.

Section 4 – 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 should be single-use only unless in short supply, in which case they may be reused unless visibly soiled and should be placed in a paper bag between uses. Alternatively, individuals can use his/her own Elastomeric Respirator. An **Elastomeric Respirator** is a tight-fitting respirator where the facepieces are made of synthetic or natural rubber material, can be repeatedly used, cleaned, disinfected, stored, and re-used. They are available as alternatives to disposable half mask filtering facepiece respirators (FFRs), such as N95.

- **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. Aerosol-generating procedures should preferably be done outdoors, where possible, in a private place to maintain the 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 be 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 5 – Masks, physical distancing, and screening testing

- Masking and physical distancing may be needed, especially during periods of higher community transmission, to keep children healthy and in school.
- CDC is advising layered protection to prevent COVID-19 transmission in school.
 - They recommend 3 feet of distance be maintained between people in schools based on studies published this past year; however, the overarching goal is to have children in schools, and if 3 feet of distance cannot be attained, other measures such as masking should be used.
 - CDC continues to recommend masking for unvaccinated persons in indoor settings. The American Academy of Pediatrics recommends masking for all students in schools.
- **We are recommending that during periods of elevated community transmission of SARS-CoV-2 (≥ 10 cases per 100,000 people or $\geq 5\%$ test positivity), masks should be worn every day as much as possible by students and staff. This excludes 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.
- When virus transmission is low (< 10 cases/100,000 or $> 5\%$ test positivity) in a community, masking is not required but still recommended for all individuals working in and attending schools.
- Although masking is generally not required for vaccinated individuals, many schools will not be easily able to track vaccinated students and staff and ensure the unvaccinated are properly wearing masks. For this reason, we are recommending that masks be worn universally.
- 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.
- 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 6 feet away. All staff members should be wearing masks.
- School-aged children should wear a cloth mask, 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. Parents should be advised to have their children practice wearing masks while at home and going about normal activities to get acclimated to wearing them all day.
- Mask breaks should preferably be done outside and/or when 6 feet of separation from others can be assured.
- In general, children playing outside do not need to wear masks. Schools may choose to have children mask outdoors when transmission is substantial or high in the community.

- Mask use should be considered the entire school year as masking prevents the spread of other respiratory viruses, including RSV, influenza, and common cold viruses. Transmission of these viruses in school will increase absenteeism because they are COVID-19 mimics and will require testing to be allowed back into school as well as due to the illnesses themselves.
- 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.
- 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 of adults triggered by a COVID case in the school as proper mask use cannot be assured. Exposure will be defined by distance and duration of exposure only (see section 6 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 (cumulatively) 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)
 - see below in section 6 for the exception to this for children wearing masks properly.

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 quarantine at home should a case occur in the school. Desks should be at least 3 feet apart where possible and all facing the same direction.

- Students should spend as little time as possible in areas where students may be in close proximity to others, such as hallways.
- Screening testing is an additional protective measure that can be used by schools to promptly identify cases and have them isolated. Screening programs work best if performed at least once per week and results are obtained rapidly. Random testing can be done or pooled testing of multiple samples together. CDC provides guidance on screening testing and its benefits.

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, 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 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, and anyone entering the isolation room should wear full personal protective equipment (PPE) – that is, 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 young school-aged children.
- Testing of children who develop symptoms at school would be ideal. A rapid antigen test should be very sensitive for the diagnosis of COVID-19 in a child or staff member who had new onset of symptoms. These tests are inexpensive and easy to administer.
- A child who is tested in the school and negative may be allowed to stay in school if symptoms are mild. Children with more severe symptoms will be sent home and call return when feeling better.
- 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 unless the sibling is fully vaccinated.
- Any child or adult (including all family members) with a known or possible COVID contact and with anyone 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 7 – Process to handle a COVID case in school

- An individual is considered a contact of a case of COVID-19 if that individual spent 15 minutes or more (cumulatively in a 24-hour period) within 6 feet of the infected person regardless of masking unless fully vaccinated.
- Contacts (child or adult) of a suspected or known case of COVID-19 do not need to quarantine if the contact is fully vaccinated or had COVID-19 within the preceding three months.
- CDC has revised its definition of close contact between students (excludes adults in the school) to the following:
 - 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.
- 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 quarantine at home (see definitions and duration of quarantine at the beginning of section 7). 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 the onset of symptoms. Enforcing physical distancing will make contact tracing much easier. Individuals wearing full PPE (i.e. school nurse with a 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 may be shut down for 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 the entire class) should be rescreened for symptoms and fever. Children who are not considered contacts (were not within six feet for ≥ 15 minutes) may be able to stay at school, but actual 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 resulting from 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 8 – 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, and the individual must have improvement of symptoms as well as be without fever for at least 24 hours. Note that isolation should start at the onset of symptoms. You should not wait for a positive test to begin isolating.

Quarantine: this is the period during which individuals with a significant exposure (within 6 feet for more than 15 minutes) to a confirmed case of COVID-19. Quarantine should begin as soon as the exposure is known, and the days should be counted from the day of the last exposure to the infected individual. Until recently, the quarantine period was 14 days. To have more people follow quarantine rules, CDC has offered alternatives.

- Since the incubation period for COVID-19 is up to 14 days, the safest thing to do is to quarantine for 14 days after the last exposure to the infected individual. This means that if you have ongoing household exposure to a case, for example, you must wait until that case is no longer contagious or can completely isolate before beginning the quarantine countdown. This means the total duration of quarantine could be 24 days (the 10 days of isolation for the infected individual plus 14 days of quarantine).
- 10 days of quarantine is now acceptable. There is a small risk (about 1%) that the person in quarantine could start shedding the virus after 10 days.
- 7 days of quarantine with a negative covid test performed on or after day 5 of quarantine. There is also a small risk (up to 10%) that the person in quarantine could start shedding the virus after this time.
 - After stopping quarantine, you should
 - Watch for symptoms until 14 days after exposure.
 - If you have symptoms, immediately self-isolate and contact your local public health authority or healthcare provider.

Wear a mask, stay at least 6 feet from others, wash their hands, avoid crowds, and take other steps to prevent the spread of COVID-19.

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 such as migraine, allergies) may return to school when symptoms have improved and afebrile for ≥ 24 hours (usual policy for any illness) 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, 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 has COVID. If the COVID test is negative, this person must complete quarantine. If the test is positive, then the isolation period for a symptomatic case starts on the first day of symptoms.
- 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 ≥ 24 hours.

- If the test is positive or no test is done (and no other pathogen identified), this person must be placed in isolation.
- Isolation should begin as soon as symptoms are recognized and should not be delayed for testing or awaiting results.

Asymptomatic children and adults

- Anyone who is a contact of a known case of COVID must be quarantined at home 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. Quarantine should be initiated as soon as a potential exposure is known to minimize exposure of additional individuals. The exceptions to this are fully vaccinated individuals and those within three months of COVID-19 infection.
 - 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
 - If anyone in the household develops symptoms of COVID during quarantine and other household members are exposed, the start date of quarantine resets to the first day of symptoms for that contact.
 - If this person remains asymptomatic during quarantine, testing for COVID is still recommended. One might consider waiting at least 4 to 5 days after the exposure to get a test. A negative test after 5 days or more of quarantine allows you to end quarantine. A positive test requires isolation from the date of the test.
 - Local public health authorities make the final decisions about how long quarantine should last, based on local conditions, and needs. Follow the recommendations of the Shelby County Health Department if you need to quarantine.
 - Options they will consider include stopping quarantine
 - After day 10 without testing
 - After day 7 after receiving a negative test result (test must occur on day 5 or later)
- 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 the algorithm for return to school.

Section 9 – School sports

- School-sponsored sports and extracurricular activities are a very important part of the overall school experience for many children. Virus transmission is increased during sports because athletes breathe more heavily, frequently shout to be heard by teammates, and physical distancing is difficult to maintain. Many sports also take place indoors. Spectators are also at elevated risk for spreading or acquiring virus due to shouting/cheering and proximity.
- Unvaccinated individuals are at increased risk for contracting and spreading virus during sports.
- Unvaccinated individuals participating in indoor sports should wear masks if physical distancing cannot be maintained.
- Testing of coaches, advisors, and participants in contact or indoor sports weekly or twice weekly (if high levels of transmission in the community) should be strongly considered
- .
 - 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 10 days because of lack of physical distance and masking in a situation where individuals are shouting and breathing heavily.

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 syncope.
- 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 pediatrics.
- 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 10 – 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.
- In general, outdoor activities do not require masking. However, this could be considered during periods of high virus transmission in the community.
- 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 11 – Participation in band, orchestra, or choir

- There is evidence that singing produces high quantities of large and small droplets. For singing in groups indoors, individuals should be spaced 6 feet apart. 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 and wearing masks may reduce virus spread through aerosols.
- Band instruments (brass and woodwind) also produce aerosols that can spread COVID-19 in differing amounts based on the instrument (straight instruments expel a 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 12 - 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.

Section 13 – Riding the bus

- Wearing of masks is required on all forms of public transportation, including school buses, regardless of vaccination status.
- Children should distance as much as possible on the bus.
- School buses should be frequently cleaned and disinfected.

Section 14 – Eating at school

- Physical distancing should be optimized as much as possible while children are lined up for food and while eating.

Foodservice can be pre-packaged, grab-and-go meals, or regular meal service as there is minimal spread of virus from surfaces and shared objects.

- Students may eat in the cafeteria, classrooms, gymnasias, or outdoors if physical distancing is maintained and monitored. Eating outdoors or in classrooms with appropriate space between children is optimal.
- Snack breaks should be taken in the classroom.
- Children should wash or sanitize their hands before touching food after removing their masks and then again after replacing their masks.

Section 15 - Appropriate restroom etiquette

- Stalls will provide adequate separation in restrooms. Alternate urinals should be used in boys' restrooms and for physical distancing.
- 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 16 – Influenza vaccine and other childhood vaccines

- 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.
- During the last year, 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 actions 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.
 - 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 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) is recommended for school-based personnel. See Section 4 - 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 IEPs and 504 Plans for each child and involve parents in decision-making. We recommend frequent communication with parents about options. After a year or more of alternate or reduced 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.

Specific guidance is available from the U.S. Department of Education (supplement 3/2020 with recent updated guidance in Summer 2021 <https://www2.ed.gov/documents/coronavirus/reopening-2.pdf> and <https://www2.ed.gov/documents/coronavirus/reopening.pdf>)

- 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.
 - 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.
- 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 4 – 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 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 Section 3 below – Mental Health/Behavioral.
 - Flexibility is encouraged in method and environment for instruction.

- Encourage parent involvement in home sessions (if applicable) for further reinforcement of learning whenever possible.
 - Encourage parents *and children* to provide feedback on new and alternate 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.

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 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 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 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.

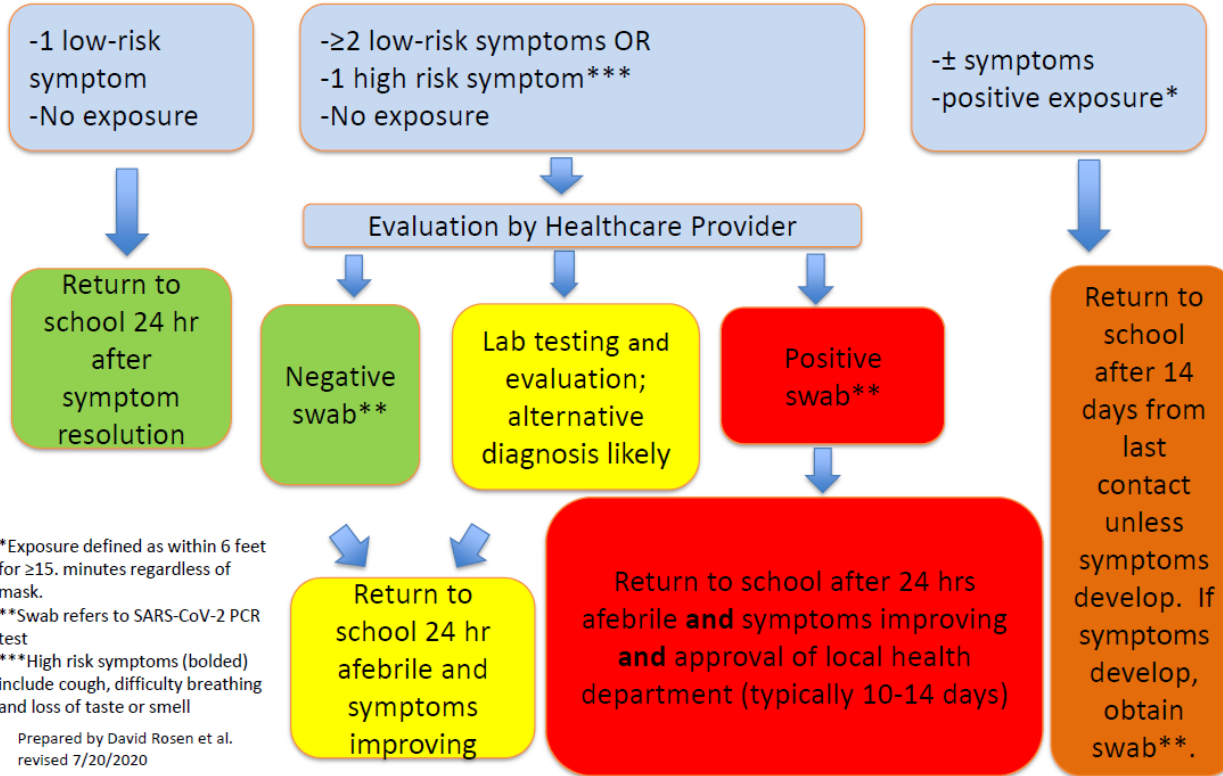
Available content includes information on normalizing mask wearing, vaccines, testing and screening, among others. Continued feedback from schools and parents will help inform what information is desired.

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

Appendices

Appendix A

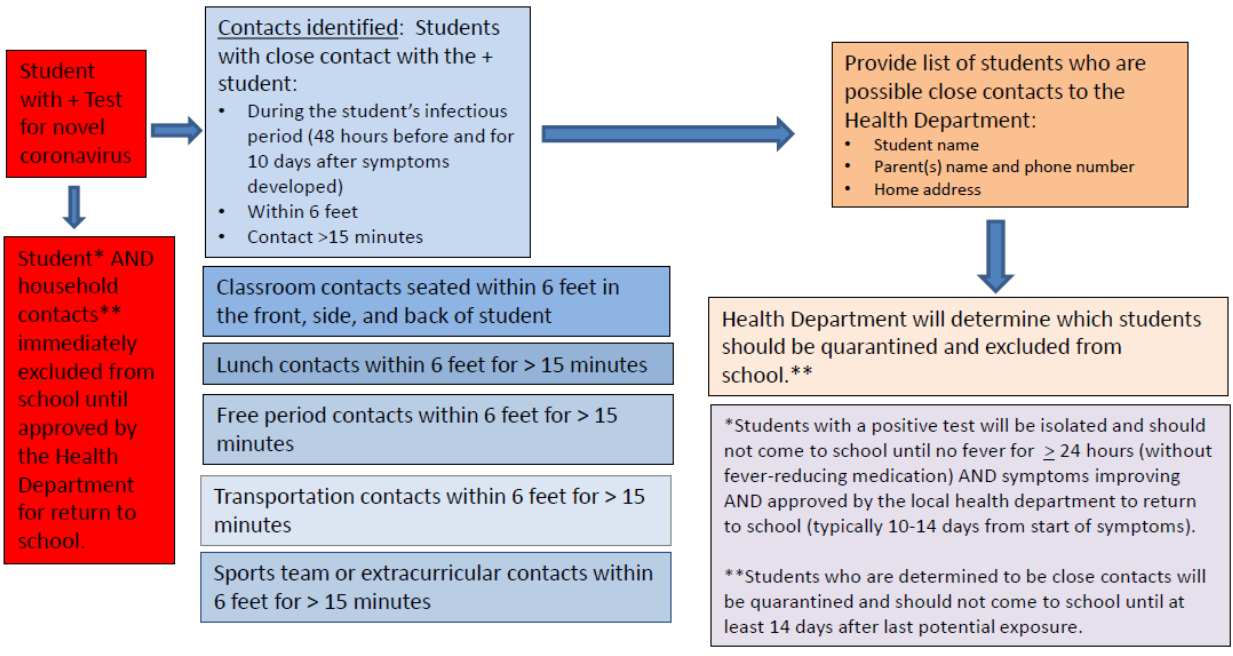
School Nurse Algorithm: Screen all students for potential COVID-19 symptoms or exposure: Any new **fever, cough, difficulty breathing, loss of taste/smell**, fever ($\geq 100.4^{\circ}\text{F}$), congestion/runny nose, nausea/vomiting/diarrhea, sore throat, headache, myalgia, or exposure* to COVID-19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



*Exposure defined as within 6 feet for ≥ 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

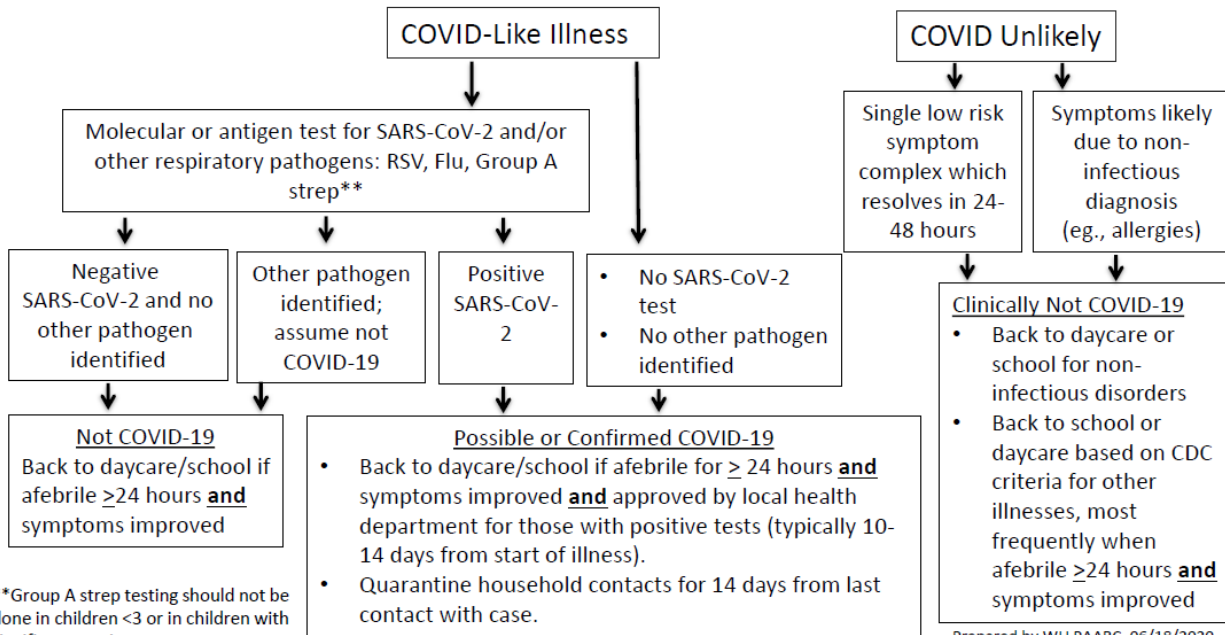
Prepared by Rachel Orscheln, revised- 7/20/2020

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

Appendix D

Levels of community transmission

Indicator - If the two indicators suggest different transmission levels, the higher level is selected	Low Transmission Blue	Moderate Transmission Yellow	Substantial Transmission Orange	High Transmission Red
Total new cases per 100,000 persons in the past 7 days	0-9.99	10-49.99	50-99.99	≥100
Percentage of NAATs ¹ that are positive during the past 7 days	0-4.99%	5-7.99%	8-9.99%	≥10.0%

¹ NAAT – nucleic acid amplification test (for example, PCR). Excludes rapid antigen tests.

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