Maryland

DEPARTMENT OF HEALTH
Dennis R. Schrader, Secretary

STATE DEPARTMENT OF EDUCATION
Mohammed Choudhury, Superintendent

Memorandum

To: Local School Superintendents
Non-Public Schools

From: Mohammed Choudhury, State Superintendent of Schools, MSDE
Dennis R. Schrader, Secretary, MDH
Jinlene Chan, MD, Deputy Secretary for Public Health Services, MDH

CC: Local Health Officers

Subject: K-12 School and Child Care COVID-19 Guidance

Date: October 27, 2021

Please find attached updated guidance developed by the Maryland Department of Health (MDH) and the Maryland State Department of Education (MSDE) to assist local school systems, nonpublic schools, and child care programs to respond to the COVID-19 pandemic.

Please note the following updates to this guidance:

- Revised language about required masking in public schools consistent with the emergency regulations promulgated by MSDE and the Maryland State Board of Education
- New modified quarantine options for consideration in school settings
- New recommendations to guide decisions about temporary suspension of in-person learning

We recommend that local school systems and nonpublic schools continue to collaborate with their local health department to determine the most appropriate policies for their setting and student population.

Questions about this guidance may be directed to Dr. Jamie Perry at 410-767-5592 or jamie.perry3@maryland.gov.

Enclosure (1)

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K-12 School and Child Care COVID-19 Guidance

Revised October 27, 2021

Contents

Introduction

The following guidance is provided by the Maryland Department of Health (MDH) and the Maryland State Department of Education (MSDE) to assist local school systems, nonpublic schools, and child care programs to respond to the COVID-19 pandemic. The COVID-19 pandemic continues to rapidly evolve. It is important to frequently check this document and its links for updated information.

By law, each local school system, nonpublic school, and child care program may set their own policies and procedures for their schools, students/children, teachers, and staff. **However, MDH and MSDE strongly recommend that these entities work with local health departments to implement the** layered prevention strategies (e.g., using multiple prevention strategies together consistently) **needed to protect students/children, teachers, and staff in their setting and adopt policies consistent with the recommendations in this guidance.**

For schools, the recommendations in this document are aimed to support opening for in-person learning at full capacity, as recommended by the CDC. Schools should not limit a return to in-person learning at full capacity due to the inability to implement a certain prevention strategy, but rather focus on other layered prevention strategies that can be implemented to keep students and staff safe and ensure continuous full-time, in-person instruction.

Where applicable, and for items not discussed in this document, such as cleaning and disinfection practices, sports and other extracurricular activities, and considerations for those with special health care needs, schools and child care programs should refer to their local health departments and CDC Guidance for COVID-19 Prevention in K-12 Schools or CDC COVID-19 Guidance for Operating Early Care and Education/Child Care for further guidance.

Layered Prevention Strategies to Reduce Transmission of SARS-CoV-2 in Schools and Child Care Programs

Schools and child care programs have mixed populations of both vaccinated and unvaccinated people, and child care programs primarily serve children who are not yet eligible for vaccination. This makes it critical that schools and child care programs work with local health departments to determine and implement the layered prevention strategies needed in their area to protect students/children, teachers, and staff. As recommended by the CDC, decisions about layered prevention strategies should be informed by monitoring levels of community transmission, COVID-19 vaccine coverage, use of screening testing to detect cases in K-12 schools, ages of children served, and the associated factors that may impact the risk of transmission and feasibility of different prevention strategies**.** There is no single strategy that, implemented alone, will create a safer school and child care environment. Instead, MDH and MSDE, in alignment with the CDC, recommend that schools and child care programs consider implementation of the following layered prevention strategies which should minimize the need

to close entire school and child care buildings, further disrupt learning, and compound the adverse health and emotional stress on children:

- Promoting vaccination among teachers, staff and students
- Consistent and correct mask use
- Physical distancing
- Screening testing to promptly identify cases, clusters and outbreaks
- Ventilation
- Handwashing and respiratory etiquette
- Staying home when sick and getting tested
- Contact tracing, in combination with isolation and quarantine
- Cleaning and disinfection

When a school or child care program cannot implement a certain strategy (ex. vaccination for children not yet eligible), it is even more important that other strategies such as consistent and correct mask use and physical distancing be utilized.

A. Promoting Vaccination

MDH and MSDE strongly recommend that all eligible Marylanders receive a COVID-19 vaccine.

Schools and child care programs can promote vaccinations among teachers, staff, eligible students/children, and their families; schools and child care programs interested in learning more about vaccine promotion strategies should refer to their local health departments and CDC guidance. While vaccination is one of the most critical strategies to help schools resume regular operations, decisions about in-person education should not be based on the level of vaccination of teachers, staff, or eligible students/children.

Policies or practices related to requesting, providing, or receiving proof of COVID-19 vaccination should comply with all relevant laws and regulations. The protocol to collect, secure, use, and further disclose this information should comply with relevant statutory and regulatory requirements, including Family Educational Rights and Privacy Act (FERPA). Existing state law and regulations already require certain vaccinations for children attending school and child care, and designated school and child care staff regularly maintain documentation of these immunization records. Similarly, designated staff who maintain documentation of student/child and staff COVID-19 vaccination status can use this information, consistent with applicable laws and regulations, to inform prevention strategies, school-based testing, contact tracing efforts, and quarantine and isolation practices. Schools and child care programs that plan to request voluntary submission of documentation of COVID-19 vaccination status should use the same standard protocols that are used to collect and secure other immunization or health status information about students/children.

B. Consistent and Correct Mask Use

Emergency regulations promulgated by MSDE and the Maryland State Board of Education and approved on 9/14/2021 by the Joint Committee on Administrative, Executive and Legislative Review (AELR), **require that all individuals cover their mouth and nose with a face covering while inside a public school facility.**

For all other schools and for child care programs, MDH and MSDE, in alignment with CDC guidance, strongly recommend the following:

- Indoor masking for all individuals age 2 years and older, including students/children, teachers, staff, and visitors, regardless of vaccination status
- Outdoor masking for people who are not fully vaccinated when they are in crowded outdoor settings or during activities that involve sustained close contact with other people

Schools and child care programs should be aware that the federal order that face masks be worn by all people while on public transportation conveyances, including public and private school buses, is still in effect.

School and child care programs should refer to CDC guidance for important exceptions and additional safety considerations related to the use of masks.

C. Physical Distancing

Local school systems, nonpublic schools, and child care programs should follow CDC guidance for physical distancing. Schools should implement physical distancing to the extent possible, but should not exclude students from in-person learning to keep a minimum distance requirement.

For schools, CDC guidance recommends maintaining at least 3 feet of physical distance between students within classrooms, combined with indoor mask wearing to reduce transmission risk. When it is not possible to maintain a physical distance of at least 3 feet, it is especially important to layer multiple other prevention strategies, such as screening testing, cohorting, improved ventilation, handwashing and respiratory etiquette, staying home when sick, and regular cleaning to help reduce transmission risk. A distance of at least 6 feet is recommended between students and teachers/staff, and between teachers/staff who are not fully vaccinated. Mask use by all students, teachers, staff, and visitors is particularly important when physical distance cannot be maintained.

In child care programs, maintaining physical distance is often not feasible, especially during certain activities (e.g., diapering, feeding, holding/comforting, etc.) and among younger children in general. When it is not possible to maintain physical distance, it is especially important to layer multiple prevention strategies such as those noted above to help reduce

transmission risk. Mask use is particularly important when physical distance cannot be maintained, especially for unvaccinated people. A distance of at least 6 feet is recommended between adults who are not fully vaccinated and between children and staff from different cohorts.

Cohorting is one of the layered prevention strategies that schools and child care programs can use to limit mixing between children and staff, especially when it is challenging to maintain physical distancing. A cohort is a distinct group of children and staff that stays together throughout the entire day and remains the same every day, so that there is minimal or no interaction between groups. The use of cohorting can limit the spread of COVID-19 between cohorts but should not replace other prevention measures within each group. MDH and MSDE recommend that child care programs follow CDC guidance on specific strategies for cohorting in child care programs.

D. COVID-19 Testing

Screening Testing in Schools

MDH and MSDE recommend that schools consider the use of screening testing as part of a layered prevention approach, in accordance with CDC guidance. Screening testing involves testing asymptomatic persons at a regular frequency (e.g. once per week). Screening testing can help promptly identify and isolate cases, quarantine those who may have been exposed to COVID-19 and are not fully vaccinated, and identify clusters to reduce the risk to in-person education.

Screening testing may be most valuable in areas with substantial or high community transmission levels, in areas with low vaccination coverage, and in schools where other prevention strategies are not implemented.

Diagnostic Testing in Schools

The use of diagnostic testing in the school setting should also be considered. With diagnostic testing, persons with symptoms and their unvaccinated close contacts are tested. At minimum, schools and child care programs should offer referrals to diagnostic testing for any student/child, teacher, or staff person who develops symptoms of COVID-19 at school or child care and to any identified close contacts in the school or child care setting.

MDH and MSDE have grant support to offer screening and diagnostic testing services in K-12 schools. Schools should note that individuals with a high school diploma or GED may be designated to collect specimens for COVID-19 testing and perform point of care antigen tests after the appropriate training. Schools that are interested in onsite testing operations should contact the MDH COVID-19 Testing Task Force at MDH.K12Testing@maryland.gov. Schools should refer to CDC guidance for specific testing recommendations when developing their testing plans.

E. Ventilation

Improving ventilation is an important COVID-19 prevention strategy for schools and child care programs. Along with other preventive strategies, including wearing a well-fitting, multi-layered mask, bringing fresh outdoor air into a building helps keep virus particles from concentrating inside. This can be done by opening multiple doors and windows, using child-safe fans to increase the effectiveness of open windows, making changes to the HVAC or air filtration systems, and selective strategic use of portable filtration. The U.S. Department of Education has specifically noted the use of American Rescue Plan education funds to improve indoor air quality for in-person instruction in schools.

MDH and MSDE strongly recommend that school facilities personnel carefully evaluate all classrooms and occupied areas for adequacy of ventilation prior to or as schools reopen, and monitor ventilation adequacy on an ongoing basis.

Strategies to improve air quality in school and child care facilities include, but may not be limited to:

- Avoiding the use of poorly ventilated spaces as much as possible
- Cleaning and properly installing air filters so that air goes through the filters, rather than around them, with as high a MERV rated filter as can be accommodated by the HVAC system
- Implementing a strict preventive maintenance program focused on air handling units and exhaust fans to ensure they are working properly
- Disabling demand-controlled ventilation systems
- Maximizing outside air by using the highest outside air setting possible for the equipment
- Opening windows and doors as much as safely possible
    - A couple of inches can significantly increase the number of air changes in the room
- Using measured CO2 levels as a good proxy of ventilation. In occupied areas, the IAC COVID-19 Risk Reduction Strategies for Reopening School Facilities set the CO2 maximum for occupied spaces at 1,200 PPM, although levels should mostly be below 1,000 PPM, and levels in the 600-800 PPM range are preferred indicating very good ventilation. If available, inexpensive portable CO2 meters can be used to evaluate areas where there is a question of ventilation adequacy.
- Utilizing portable HEPA or other high efficiency air filtration units, which can be effective in small spaces such as offices, health suites/nursing suites, and isolation rooms (particularly if they are poorly ventilated), though they are usually less effective for larger areas
- Minimizing time in enclosed spaces, and maximizing time outdoors as much as possible (when appropriate)
- Avoiding the use of temporary barriers, particularly desk partitions, because they reduce ventilation and have not been shown to protect the users from COVID infection.

MDH and MSDE recommend that schools and child care programs refer to CDC guidance Ventilation in Schools and Child Care Programs for additional strategies to improve indoor air quality in their settings.

F. When to Stay Home and Get Tested

It is important for schools and child care programs to stress and frequently reinforce that students/children, teachers, and staff who are sick or have any COVID-19 symptoms should not attend or work in a school or child care program and should be referred to their healthcare provider for evaluation and testing.

In addition, students/children, teachers, and staff should stay at home if they:

- Have not completed quarantine (if recommended) after having been in close contact with someone diagnosed with COVID-19 or suspected of having COVID-19;
- Are waiting for a COVID-19 test result due to symptoms; or
- Have been diagnosed with COVID-19 and have not completed isolation.

Schools and child care programs should communicate procedures for notifying the school or child care program of absences due to illness related to COVID-19 symptoms and the requirement for timely pick up of a student/child or staff who has a fever or exhibits symptoms while at school or child care. Each school and child care program should identify a room or other space for isolation of persons who become ill during the day that is separate and distinct from spaces that are used for other purposes and provides the appropriate level of safety and supervision for an ill student/child.

Schools and child care programs should follow the MDH/MSDE guidance entitled *"Response to Confirmed Case of COVID-19 and Persons with COVID-19 Symptoms in Schools and Childcare"* (attached to this document) for exclusion, isolation, and quarantine recommendations as well as communication and notification processes.

G. Contact Tracing in Combination with Isolation and Quarantine

Local school systems, nonpublic schools, and child care programs should collaborate with state and local health departments to report and provide information about COVID-19 cases and people exposed to COVID-19 within these settings in accordance with applicable laws and regulations. This allows contact tracing to identify which students/children, teachers, and staff with positive COVID-19 test results should isolate, and which close contacts should quarantine.

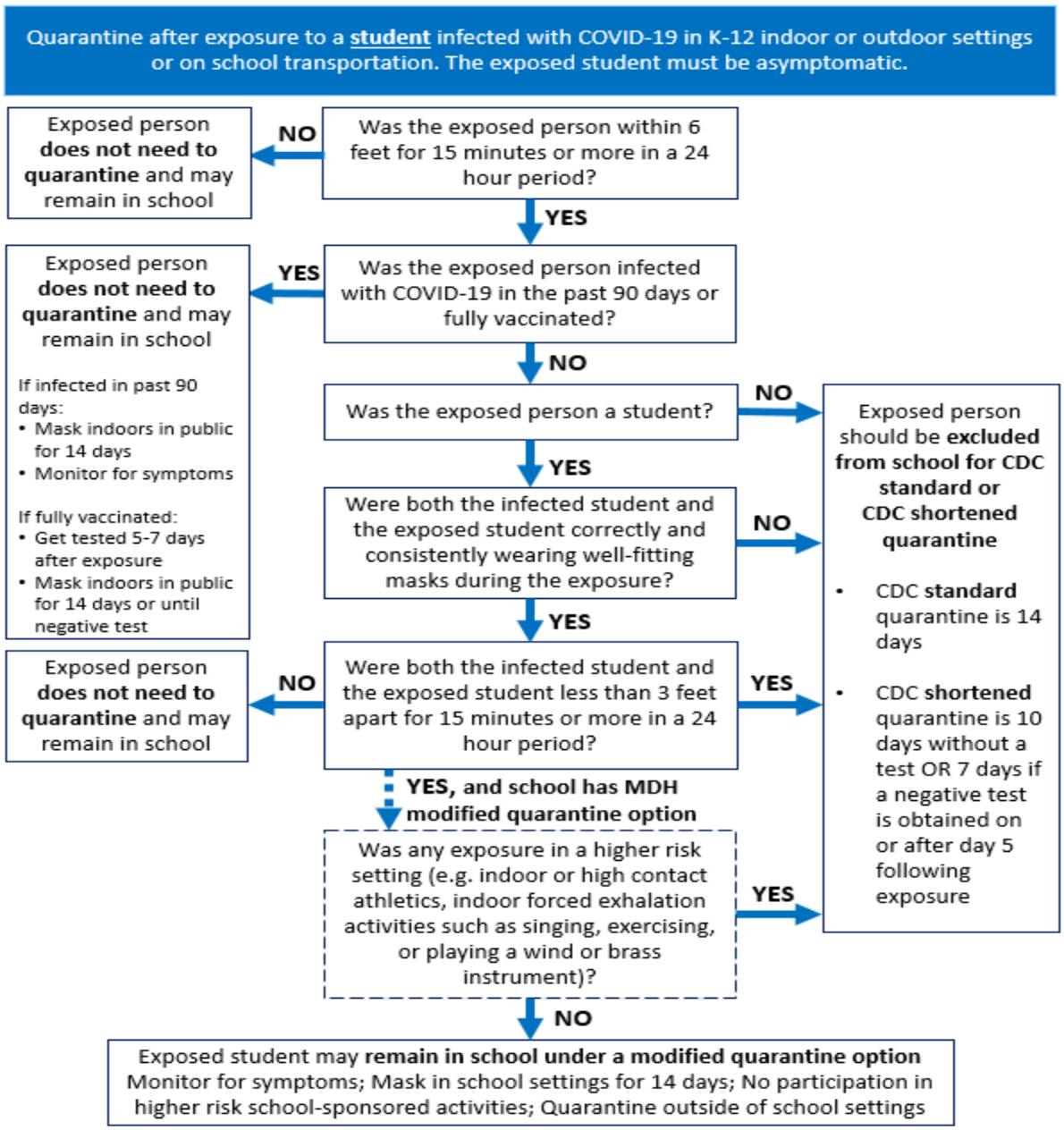
Who Should Isolate

Persons with COVID-19 should **isolate** and may return to school or child care when they have completed isolation in accordance with CDC guidance. Persons with COVID-19 should isolate regardless of presence of symptoms or vaccination status.

Who Should Quarantine

Close contacts of a person with COVID-19 who was in the school or child care building should be identified for the purpose of making quarantine recommendations. Based on CDC guidance, asymptomatic fully vaccinated persons are not currently required to quarantine following an exposure to someone with COVID-19.

Figure 1. Flow diagram to help determine who should quarantine and for how long following exposure to an infected **student**, given local school policies and approaches to quarantine.



NOTE: If either the infected person or exposed person is a **teacher/other staff**, and the exposed person was within 6 feet for 15 minutes or more in a 24 hour period, the exposed person should be excluded from school for **CDC standard or CDC shortened quarantine.**

Length of Quarantine
For unvaccinated close contacts who should quarantine, a **CDC standard quarantine** period of 14 days remains the safest option.

Based on guidance from the CDC, the following options for **CDC shortened quarantine** may be an acceptable alternative in K-12 schools depending upon local circumstances and resources:

- Quarantine can end after Day 10 if NO symptoms have been reported during daily monitoring; OR
- Quarantine can end after Day 7 if a diagnostic specimen (collected on Day 5 or later) tests negative and if NO symptoms have been reported during daily monitoring. The specimen may be collected and tested within 48 hours before the time of planned quarantine discontinuation, but quarantine cannot be discontinued earlier than after Day 7.

When a person meets these criteria and quarantine is ended early, all of the following must be implemented:

- Daily symptom monitoring continues through Day 14; AND
- Persons are counseled regarding the need to adhere strictly to all recommended mitigation strategies including correct and consistent face mask use, physical distancing, and self-monitoring for symptoms of COVID- 19 through Day 14; AND
- Persons are advised that if any symptoms develop, they should immediately self-isolate and contact their health care provider to determine if they need to be tested and how long they should be excluded from work or school/child care.

For persons that are unable to comply with correct and consistent face mask use such as young children and persons with a disability or medical condition that makes wearing a mask unsafe, a shorter quarantine option may NOT be used and these persons should quarantine for a full 14 days.

NOTE: Child care programs may use the CDC shortened quarantine period of 10 days for a child or staff person when all of the criteria above can be met. Physical distancing should be maintained when masks must be removed while eating and during naptime.

MDH Modified Quarantine Options for K-12 Schools
MDH and MSDE recognize that there is a lack of data on modified quarantine options in K-12 school settings. However, studies have shown extremely low risk of COVID-19 transmission in classroom settings when face masks were used appropriately by both the person with COVID-19 infection and the potentially exposed person, as well as having multiple layers of prevention measures in place to prevent transmission. While a 14-day quarantine period remains the safest option to reduce the risk of in-school transmission, the risk of in-school transmission

must be balanced with the negative impact of prolonged and repeated quarantine on students and staff.
Some local school systems and nonpublic schools may choose to modify their approach to quarantine. If a local school system or school chooses to implement any of the modified quarantine options below, MDH and MSDE strongly recommend the following:

- All individuals should be required to wear masks when inside a school facility.
- Local school systems/schools should ensure that multiple layered prevention strategies are in place.
- Close contacts in the school setting should continue to be identified, notified, and reported to local health departments for the purposes of contact tracing.
- Close contacts identified in the school setting should continue to quarantine outside of school settings and should not participate in higher risk school-sponsored activities (ex. indoor or high contact athletics, band, chorus) for the duration of the typical quarantine period.
- Local school systems/schools should collect and track data on COVID-19 cases and close contacts to ensure that use of modified quarantine options are not contributing to increased COVID-19 transmission within schools.
- Parents/students should be given the ability to opt out of a modified quarantine option and quarantine at home per current CDC recommendations.
- In the setting of a school COVID-19 outbreak, if there is indication of ongoing or uncontrolled transmission associated with the school or a school-sponsored activity, modified quarantine options might not be appropriate and other outbreak control measures may be required, as directed by the local health department.

The following **MDH modified quarantine** options may be considered for asymptomatic unvaccinated students who are identified as close contacts of a COVID-19 case in a K-12 setting. Individual schools can select one of these modified quarantine option to implement.

NOTE: These options do not apply to teachers, staff, or other adults in the school setting. In addition, exposures that are higher risk or occur where masks are not being worn do not qualify for modified quarantine (e.g. lunch, indoor or high contact athletics, indoor forced exhalation activities such as singing, exercising, or playing a wind or brass instrument).

1. Modified quarantine with implementation of “test to stay” protocols

   While each of the modified quarantine options poses a risk for in-school COVID-19 transmission, the “test to stay” option potentially poses the least amount of risk. With frequent COVID-19 testing of close contacts, there is an increased likelihood that infected asymptomatic students will be identified quickly. These students can then be excluded and isolated in order to prevent infection of others in the school setting.

   Asymptomatic unvaccinated students who are a close contact of a student with COVID-19 in K-12 indoor or outdoor settings or school transportation AND both the infected

student and exposed student(s) were correctly and consistently wearing well-fitting masks for all exposures are not required to quarantine if the students are tested daily for at least 5 days (or a reasonable alternative such as days 1, 3, 5, and 7) following exposure and remain asymptomatic. The exposed student(s) should continue to wear a mask for 14 days in school settings.

Schools should ensure that testing can be done on-site in order to implement this option.

2. Modified quarantine with implementation of weekly screening testing

   This modified quarantine option potentially poses risk for in-school COVID-19 transmission. COVID-19 screening tests, when performed on close contacts, can provide the opportunity to identify asymptomatic infected students. These students can then be excluded and isolated in order to prevent infection of others in the school setting. However, based on the frequency and timing of testing, screening testing may not identify all infected students, leading to the potential for in-school transmission to occur.

   Asymptomatic unvaccinated students who are a close contact of a student with COVID-19 in K-12 indoor or outdoor settings or school transportation AND both the infected student and exposed student(s) were correctly and consistently wearing well-fitting masks for all exposures are not required to quarantine if they are actively participating in at least weekly school screening testing and remain asymptomatic. The exposed student(s) should continue to wear a mask for 14 days in school settings.

3. Modified quarantine with correct and consistent use of well-fitting masks

   This modified quarantine option potentially poses the highest risk for in-school COVID-19 transmission. Without any COVID-19 test results for close contacts, there is a greater likelihood that infected asymptomatic students will be present in school settings and infect others. Before adoption, schools should consult with their local health department and carefully consider whether this is an appropriate option for their student and staff population and school setting.

   Asymptomatic unvaccinated students who are a close contact of a student with COVID-19 in K-12 indoor or outdoor settings or school transportation AND both the infected student and exposed student(s) were correctly and consistently wearing well-fitting masks for all exposures are not required to quarantine, as long as they remain asymptomatic. The exposed student(s) should continue to wear a mask for 14 days in school settings.

NOTE: MDH modified quarantine options may be considered in child care programs when all of the children are age 5 years and above and all of the conditions described above can be met.

Local school systems, nonpublic schools, and child care programs should work with their local health departments to determine the appropriate quarantine approach for their population of students/children, teachers, and staff. Table 1 summarizes the available approaches to quarantine, including eligibility, length of time to quarantine, and additional requirements.

Table 1. Approaches to quarantine for asymptomatic unvaccinated persons who are close contacts of a person with COVID-19 in K-12 indoor and outdoor settings and on school transportation

	Approaches to Quarantine* for Asymptomatic Unvaccinated Persons Who are Close Contacts of a Person with COVID-19 in K-12 Indoor and Outdoor Settings and on School Transportation				
	CDC Standard Quarantine	**CDC Shortened Quarantine**	**MDH Modified Quarantine Options**		
			Test to Stay	**Weekly Screening Testing**	**Correct and Consistent Use of Well-Fitting Masks**
Eligible Persons	Teachers, staff, and students, regardless of whether masks were worn		Students exposed to students, both correctly and consistently wearing well-fitting masks for all exposures		
Applicable for Higher Risk Exposures**	Yes		No		
Length of Exclusion from School	14 days	10 days OR 7 days with a negative test on or after day 5 after exposure	No exclusion if the exposed students are tested daily for at least 5 days (or a reasonable alternative) following exposure	No exclusion if the exposed students are participating in at least weekly school screening testing	No exclusion if the infected student and exposed students were correctly and consistently wearing well-fitting masks for all exposures
Additional Requirements	● Monitor for symptoms		● Monitor for symptoms ● Mask in school settings for 14 days ● No participation in higher risk school-sponsored activities** ● Quarantine outside of school settings		

*Risk of in-school transmission increases from left to right across quarantine options.
**E.g. Indoor or high contact athletics, indoor forced exhalation activities such as singing, exercising, or playing a wind or brass instrument.

Suspension of In-Person Learning

While the goal is to continue in-person learning whenever possible, MDH and MSDE recommend the following criteria for temporary suspension of in-person learning in a specific school (or classroom/cohort within a school):

- When there is evidence of substantial, uncontrolled in-school transmission
- When schools need additional time to identify, notify, and exclude close contacts
- When there are logistical or safety concerns arising from the number of cases and close contacts
- When discussed with and recommended by local public health and medical professionals

Decisions around the suspension of in-person learning for an entire school or a portion of a school due to COVID-19 as well as the duration of the suspension of in-person learning should be made in coordination with the local health department and the local school system as applicable.

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Response to a Confirmed Case of COVID-19 and Persons with COVID-19 Symptoms in Schools and Child Care

Updated October 27, 2021

This guidance applies to persons with confirmed COVID-19, regardless of whether they have symptoms, and persons with symptoms of COVID-19 (including probable cases who have symptoms and exposure) and is to be implemented by schools and child care programs in collaboration with the local health department (LHD). This guidance is meant to supplement, where necessary, current communicable disease and outbreak investigation processes, current child care and school health services illness management processes, and current LHD COVID-19 response processes. Schools and local health departments should also refer to the CDC guidance, Considerations for Case Investigation and Contact Tracing in K-12 Schools and Institutions of Higher Education.

Communication and Notification

- Schools and child care programs should develop processes to inform staff and parents that they are expected to notify the school or child care program as soon possible about absences due to illness, when a staff person or student/child has tested positive for COVID-19, and when a staff person or student/child has had close contact with a person with confirmed or probable COVID-19;
- Schools and child care programs should communicate to parents the expectation that students/children who become ill at school or child care MUST be picked up within a specified period of time;
- Schools and child care programs must follow existing procedures for reporting communicable diseases (COMAR 10.06.01) and notify the LHD when a student/child or staff member has tested positive for COVID-19. Child care programs should also notify their licensing specialist;
- While the LHD should lead the processes of case investigation and contact tracing, schools and child care programs play a key role in obtaining and communicating critical information and should have a plan to collaborate and coordinate with the LHD for case investigation and contact tracing procedures including determining the role of the school or child care administrator, school nurse, and the LHD;
- Schools and child care programs should provide written notification to all identified close contacts. The notification should include specific quarantine instructions (as applicable) based upon MDH and local quarantine guidance. The notification should

also make it clear that the contact should expect a call from health department contact tracers.

Exclusion, Isolation, Quarantine, and Return to School and Child Care

- If a student/child or staff member develops symptoms of COVID-19 while they are at school or child care**,** the school or child care program should:
    - Safely isolate the person in the designated isolation area with appropriate supervision;
    - If it is safe to do so, place a face covering/mask on the person if they are 2 years of age or above and not wearing one;
    - If at school, the school health services staff member should don the appropriate PPE and conduct the appropriate determination of the student's condition based on presenting symptoms;
    - Begin the process for the person to vacate the school or child care program as soon as possible;
    - Follow CDC guidance for cleaning and disinfecting the facility when someone is sick.
- The school or child care program should follow the *Decision Aid: Exclusion and Return for Persons with COVID-19 Symptoms and Close Contacts in Child Care, Schools, and Youth Camps* (attached);
- The school or child care program should also follow the instructions from the LHD for all matters regarding exclusion, isolation, quarantine, and return to school or child care for persons with confirmed or probable COVID-19 and close contacts; and
- If the number of laboratory confirmed cases of COVID-19 meets the definition of an outbreak, the response decisions, including possible suspension of in-person learning, child care classroom/program closure, and recommendations for COVID-19 testing of staff and students/children will be made by the LHD and the local school system as applicable.

Decision Aid: Exclusion and Return for Persons with COVID-19 Symptoms and Close Contacts in Child Care, Schools, and Youth Camps

For the purposes of this decision aid, **COVID-19 symptoms** are any ONE of the following: fever of 100.4° or higher, sore throat, cough, difficulty breathing, diarrhea or vomiting, new onset of severe headache (especially with fever), or new loss of taste or smell. For persons with chronic conditions such as asthma, the symptoms should represent a change from baseline.

Exclude all persons (child, care provider, educator, other staff) with COVID-19 symptoms and recommend evaluation by a health care provider and testing for COVID-19[1]	Recommendations for the person with symptoms who is NOT FULLY VACCINATED Individuals are fully vaccinated 2 weeks after receiving either 1) both doses of a 2-dose vaccine series or 2) a single dose vaccine.	Recommendations for asymptomatic close contacts of the person with symptoms
Person has symptoms and positive test for COVID-19 or clinical diagnosis of COVID-19	May return when it has been at least 10 days since symptoms first appeared AND no fever for at least 24 hours without fever-reducing medication AND improvement of other symptoms.	Close contacts who are fully vaccinated[2] OR have been infected with COVID-19 in the past 90 days do not need to quarantine. All other close contacts should follow MDH and local quarantine guidance.
Person has symptoms and negative test for COVID-19	If no known exposure, may return when symptoms have improved, no fever for 24 hours without fever-reducing medication, AND applicable criteria in the Communicable Diseases Summary have been met. If known exposure, may return when quarantine completed according to MDH and local guidance.	Close contacts do not need to quarantine.
Person has symptoms and health care provider documents symptoms are due to a specific alternative diagnosis (ex. strep throat, otitis media, pre-existing condition such as asthma)	If no known exposure, may return when symptoms have improved, no fever for at least 24 hours without fever-reducing medication, AND applicable criteria in the Communicable Diseases Summary have been met. If known exposure, may return when quarantine completed according to MDH and local guidance.	Close contacts do not need to quarantine.
Person has symptoms with no negative test for COVID-19 AND no specific alternative diagnosis	If no known exposure, may return when it has been at least 10 days since symptoms first appeared AND no fever for at least 24 hours without fever-reducing medication AND improvement of other symptoms.	Close contacts do not need to quarantine.
	If known exposure, may return when it has been at least 10 days since symptoms first appeared AND no fever for at least 24 hours without fever-reducing medication AND improvement of other symptoms.	Close contacts who are fully vaccinated[2] OR have been infected with COVID-19 in the past 90 days do not need to quarantine. All other close contacts should follow MDH and local quarantine guidance.

[1]For persons with symptoms who were previously infected with COVID-19 and recovered, follow CDC guidance.
[2]Fully vaccinated persons who are exposed to someone with COVID-19 should follow CDC guidance.

Decision Aid: Exclusion and Return for Persons with COVID-19 Symptoms and Close Contacts in Child Care, Schools, and Youth Camps

For the purposes of this decision aid**, COVID-19 symptoms** are any ONE of the following: fever of 100.4° or higher, sore throat, cough, difficulty breathing, diarrhea or vomiting, new onset of severe headache (especially with fever), or new loss of taste or smell. For persons with chronic conditions such as asthma, the symptoms should represent a change from baseline.

Exclude all persons (child, care provider, educator, other staff) with COVID-19 symptoms and recommend evaluation by a health care provider and testing for COVID-19 if indicated[1]	Recommendations for the person with symptoms who is FULLY VACCINATED Individuals are fully vaccinated 2 weeks after receiving either 1) both doses of a 2-dose vaccine series or 2) a single dose vaccine.	Recommendations for asymptomatic close contacts of the person with symptoms
Person has symptoms and positive test for COVID-19 or clinical diagnosis of COVID-19	May return when it has been at least 10 days since symptoms first appeared AND no fever for at least 24 hours without fever-reducing medication AND improvement of other symptoms.	Close contacts who are fully vaccinated[2] OR have been infected with COVID-19 in the past 90 days do not need to quarantine. All other school close contacts should follow MDH and local quarantine guidance.
Person has symptoms and negative test for COVID-19	May return when symptoms have improved, no fever for 24 hours without fever-reducing medication, AND applicable criteria in the Communicable Diseases Summary have been met.	Close contacts do not need to quarantine.
Person has symptoms and health care provider documents symptoms are due to a specific alternative diagnosis (ex. strep throat, otitis media, pre-existing condition such as asthma)	May return when symptoms have improved, no fever for at least 24 hours without fever-reducing medication, AND applicable criteria in the Communicable Diseases Summary have been met.	Close contacts do not need to quarantine.
Person has symptoms and no negative test for COVID-19 AND no specific alternative diagnosis	If no known exposure, may return when symptoms have improved, no fever for 24 hours without fever-reducing medication, AND applicable criteria in the Communicable Diseases Summary have been met. Person should have written health care provider assessment that COVID-19 testing is not indicated and risk of COVID-19 is low.	Close contacts do not need to quarantine.
	If known exposure, may return when it has been at least 10 days since symptoms first appeared AND no fever for at least 24 hours without fever-reducing medication AND improvement of other symptoms.	Close contacts who are fully vaccinated[2] OR have been infected with COVID-19 in the past 90 days do not need to quarantine. All other close contacts should follow MDH and local quarantine guidance.

[1]For persons with symptoms who were previously infected with COVID-19 and recovered, follow CDC guidance.
[2]Fully vaccinated persons who are exposed to someone with COVID-19 should follow CDC guidance.