#StayStrongNC

ChildCareStrongNC
Public Health Toolkit

INTERIM GUIDANCE
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NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

What's Inside

What's New :

- The Toolkit has been updated to align with current CDC COVID-19 Guidance for Operating Early Care and Education/Child Care Programs and CDC's updated guidance from July 27, 2021.

- Each section of the Toolkit has been organized into three categories that prioritize implementation of the strategies that have been shown to be most effective in lowering the risk of COVID-19 exposure and spread in child care settings.

  - Strategies that are **required** are based on existing North Carolina laws and child care rules and must be followed by all child care providers.

  - Strategies that **NC DHHS recommends that child care programs require**. These strategies, if not implemented, create conditions of high risk for COVID-19 exposure and spread. NCDHHS strongly advises that child care programs adopt all the strategies in these sections.

  - Strategies that child care programs **should consider** adopting. These are strategies to provide additional layers of prevention and that, if implemented, will further reduce the risk of COVID-19 exposure and spread.

- Streamlined content, including reduced duplication of information, throughout the Toolkit based on the latest known facts and data around COVID-19

- Included guidance regarding who is now permitted in child care facilities

- Tailored the Toolkit for the child care audience by editing language to read "child/staff person" in the Summary Table for Returning from Exclusion

What Do We Know about COVID-19 and Child Care Settings?

Current Public Health Guidance

After months of decline, North Carolina is experiencing a rapid increase in COVID-19 cases and hospitalizations among those who are unvaccinated. The Delta variant, which is now the predominant strain of the COVID-19 virus in North Carolina, is significantly more contagious than the original virus. While the original virus spread from one person to an average of two or three people, the Delta variant is spreading from one person to an average of six people. Therefore, unvaccinated people are at greater risk of catching and spreading COVID-19, and they pose a risk to children under 12 who cannot be vaccinated and those who are immunocompromised. Getting vaccinated is the most effective way to prevent serious illness, hospitalizations and death, and slow community spread. Rigorous clinical trials among thousands of people ages 12 and older, have proven that vaccines are safe and effective.
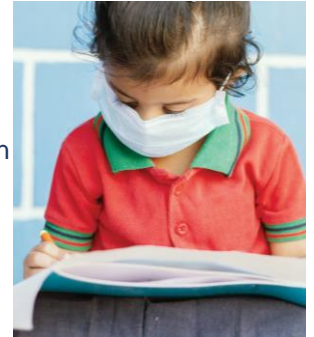
On July 9, 2021, the **Centers for Disease Control (CDC)** issued updated COVID-19 Guidance for Operating Early Care and Education/Child Care Programs.
Key takeaways include:

- The most effective way to end the COVID-19 pandemic is to get vaccinated. Child care programs should encourage people who can be vaccinated to do so. This will help protect staff and children in their care, as well as their families.

- Since children in child care are not eligible for vaccination at this time, guidance focuses on using layered prevention strategies together to protect children and adults who are not fully vaccinated.
    - Face coverings should continue to be worn indoors by everyone aged 2 and older.

- Child care programs should follow guidance from their local health department. They will be monitoring the number of cases in the community, how many people in the community are vaccinated, and outbreaks/clusters.

In addition, the **American Academy of Pediatrics (AAP)** has Guidance Related to Childcare During COVID-19 that includes the importance of:

- Well-child care, routine childhood immunizations, and screenings for children during the COVID-19 pandemic
- A daily health check for staff and children **before** drop-off/check-in that includes at least a daily temperature check, other COVID-19 symptoms and any history of contact with a confirmed case of COVID-19.
- Exclusion policies for when someone becomes sick with COVID-19 or has a history of contact with someone with COVID-19 and appropriate closure if a child, household member, or staff member has a confirmed case of COVID-19.
- COVID-19 vaccination for all eligible child care providers.
- Supporting:
    - Breastfeeding mothers
    - Emotional and behavioral health of children and staff
    - Children with special health care needs
- Physical distancing, cohorting and limiting classroom size

With rapidly accelerating viral transmission and the increased contagiousness of the Delta variant, on July 27th, 2021, CDC updated guidance to include recommendations for universal indoor masking in certain settings, regardless of vaccination status.

Prevention Strategies

This Toolkit has been updated to provide child care providers with greater flexibility in implementing layered prevention strategies based on:

- current COVID-19 trends in the community and
- updated CDC and AAP guidance.

Each section of the Toolkit has been organized into three categories that prioritize implementation of the strategies that have been shown to be most effective in lowering the risk of COVID-19 exposure and spread in child care settings.

- Strategies that are **REQUIRED** are based on existing North Carolina laws and child care rules and must be followed by all child care providers.
- Strategies that **SHOULD** be implemented:
    - These strategies, if not implemented, create conditions of high risk for COVID-19 exposure and spread.
    - **NCDHHS strongly advises that child care programs adopt all the strategies in these sections.**
- Strategies that child care programs COULD CONSIDER adopting:
    - These are strategies to provide additional layers of prevention and that, if implemented, will further reduce the risk of COVID-19 exposure and spread.

Child care providers should continue to consult with local public health officials about transmission and vaccine rates in their community to make operational decisions. Child care programs should consider developing a COVID-19 policy to inform staff and families of how they will plan to implement the guidance in this toolkit.

Child care providers should continue to maintain awareness of:

- the effectiveness of their current policy
- any new restrictions by state or local public health leaders that are necessary to control the spread of the disease.

All of these COVID-19 prevention strategies remain critical to protect people, including children, families, and staff, who are not fully vaccinated, especially in areas of moderate-to-high community transmission levels. When considering whether and how to remove prevention strategies, one prevention strategy should be removed at a time and the facility should closely monitor:

- increases in COVID-19 cases among children and staff
- community outbreaks and clusters.

Promoting Vaccination

The most effective way to end the COVID-19 pandemic is to get vaccinated. Evidence shows that COVID-19 vaccines are safe and effective at preventing COVID-19, including severe illness and death. COVID-19 vaccines can also reduce the risk of people spreading COVID-19.

People 12 years and older are now eligible for COVID-19 vaccination, but most child care programs serve children under 12 years old. Child care programs can promote vaccinations among staff and families, including pregnant women, by providing information about COVID-19 vaccination, encouraging vaccine trust and confidence, and establishing supportive policies and practices that make getting vaccinated as easy and convenient as possible.

When promoting COVID-19 vaccination, consider that certain communities and groups have been disproportionately affected by COVID-19 illness and severe outcomes, and some communities might have experiences that affect their trust and confidence in the healthcare system. Teachers, staff, and families may differ in their level of vaccine confidence. Child care administrators can adjust their messages to the needs of their families and community and involve trusted community messengers as appropriate, including those on social media, to promote COVID-19 vaccination among people who may be hesitant to receive it.

Child care programs can promote vaccines by:

- Visit yourspotyourshot.nc.gov or call 1-888-675-4567 to find out where staff and families can get vaccinated against COVID-19 in the community and promote COVID-19 vaccination locations near the child care program.
- Encourage staff and families, including extended family members who have frequent contact with children in the child care program, to get vaccinated as soon as they can.
- Identify potential barriers that may be unique to the workforce and implement policies and practices to address them.
- Find ways to adapt key messages to help families and staff become more confident about the vaccine by using the language, tone, and format that fits the needs of the community and is responsive to concerns. Visit
- Use NC DHHS COVID-19 Vaccine Communication Toolkit to promote COVID-19 vaccination.
- Host information sessions to connect parents and guardians with information about the COVID-19 vaccine. Child care staff and health professionals such as Child Care Health Consultants can be trusted sources to explain the safety, effectiveness, and benefits of COVID-19 vaccines and answer frequently asked questions.
- Offer flexible, supportive sick leave options (e.g., paid sick leave) for employees to get vaccinated or who have side effects after vaccination. See CDC's Post-vaccination Considerations for Workplaces for more information.
- Promote vaccination information as part of enrollment activities for families entering the child care program.

Recommendations for prevention strategies may differ based on vaccination status, for example, participating in screening testing programs or quarantine after a close contact with someone with a confirmed case of COVID-19.

All child care programs should:

- Require staff to report vaccination status.
- Require staff who are unvaccinated, or do not disclose vaccine status, participate in screening/testing programs.

More CDC resources on vaccination:

- COVID-19 Vaccination Information
- COVID-19 Vaccines for Teachers, School Staff, and Childcare Workers
- COVID-19 Vaccine Toolkit for School Settings and Childcare Programs

Face Coverings

When people wear a mask correctly and consistently, they protect others as well as themselves. Consistent and correct mask use is especially important indoors and when physical distancing cannot be maintained.

Child care programs should:

- Require all adults and all children two (2) years or older (i.e. required regardless of vaccination status) wear a face covering at all times when **indoors**, unless:
    - the person (or family member for a child) states that an exception applies or
    - the person is eating or sleeping.
- Require passengers and staff wear a face covering on buses, vans, and other group and public transportation. Required by Center for Disease Control Order.
- Share guidance and information with staff, children, and families on the proper use, wearing, removal, and cleaning of cloth face coverings, such as CDC's guidance on wearing and removing cloth face masks and CDC's use of cloth face coverings. Visit NCDHHS' COVID19 response site for more information about face coverings, and to access sign templates that are available in English and Spanish.

> The following groups should **not wear face coverings**
> - Children under 2 years of age
> - A person who cannot wear a mask, or cannot safely wear a mask, because of a disability as defined by the Americans with Disabilities Act (ADA) (42 U.S.C. 12101 et seq.). Discuss the possibility of reasonable accommodation with workers who are not fully vaccinated who are unable to wear or have difficulty wearing certain types of masks because of a disability.

- Provide masks to those children and staff who need them (including on transportation), such as children who forgot to bring their mask or whose families are unable to afford them. No disciplinary action should be taken against a child who does not have a mask
- Exceptions to face coverings are people who:
    - Should not wear a face covering due to any medical or behavioral condition or disability (including, but not limited to, any person who has trouble breathing, or is unconscious or incapacitated, or is otherwise unable to put on or remove the face covering without assistance);
    - Is under two (2) years of age;
    - Is actively eating or drinking;
    - Is seeking to communicate with someone who is hearing-impaired in a way that requires the mouth to be visible;
    - Is giving a speech for a broadcast or to an audience;
    - Is working at home or is in a personal vehicle;
    - Is temporarily removing his or her face covering to secure government or medical services or for identification purposes;
    - Would be at risk from wearing a face covering at work, as determined by local, state, or federal regulations or workplace safety guidelines;
    - Has found that his or her face covering is impeding visibility to operate equipment or a vehicle; or
    - Is a child whose parent, guardian, or responsible person has been unable to place the Face Covering safely on the child's face.

To facilitate learning and social/emotional development, consider having staff wear a clear face covering or a cloth face covering with a clear panel when interacting with young children, children learning to read, or when interacting with people who rely on reading lips.

When face coverings are worn by child care providers and staff in the workplace, the face coverings should meet one of the following criteria:

- CDC mask recommendations
- ASTM International Standard Specification for Barrier Face Coverings
- NIOSH Workplace Performance and Workplace Performance Plus masks

Resources on face coverings

- How masks control the spread of SARS-CoV-2
- How to select, wear, and clean your mask

Cohorting and Physical Distancing

Maintaining physical distance is often not feasible in a child care setting, 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 in child care settings, it is especially important to layer multiple prevention strategies, such as cohorting, masking indoors, improved ventilation, handwashing, covering coughs and sneezes, and regular cleaning to help reduce transmission risk. Use of face coverings is particularly important when physical distance cannot be maintained. A distance of at least 6 feet is recommended between adults who are not fully vaccinated. People who are fully vaccinated do not need to physically distance.

Cohorting: Cohorting means keeping people together in a small group and having each group stay together throughout an entire day. Cohorting can be used to limit the number of children and staff who come in contact with each other, especially when it is challenging to maintain physical distancing, such as among young children, particularly in areas of moderate-to-high transmission levels. The use of cohorting can limit the spread of COVID-19 between cohorts but should not replace other prevention measures within each group.

Child care programs are required to:

- **Maintain ratios and adhere to the Revised Flexibility in Policy and Regulatory Requirements for Child Care Providers.** [Required by NC Child Care Rules.]

Child care programs should:

- Maintain 6 feet of distance between adults who are not fully vaccinated, to the greatest extent possible.
- Consistent cohorting by placing children and child care providers into distinct groups that stay together throughout the entire day.
    - If possible, your child care groups should include the same children each day, and the same child care providers should remain with the same group of children each day.
    - Limiting mixing between groups such that there is minimal or no interaction between groups or cohorts.
    - Maintaining at least 6 feet between children and staff from different cohorts.

- Allow access for:
    - Parents/caregivers (to drop off and pick up children) and mothers who are breastfeeding to meet the nutritional needs of breastfeeding infants
    - Professionals who support children with special health care needs and/or behavioral/mental health needs to provide services and/or assessment.
    - Early intervention service coordinators and providers for children with Individualized Family Services Plans (IFSP)

- Itinerant teachers and related service providers for children Individualized Education Plans (IEP)
- Regulatory agencies
- Technical assistance providers.

- Limit non-essential visitors, volunteers and activities involving external groups or organizations with people who are not fully vaccinated.

Child care programs could consider:

- Developing plans or procedures that maintain prevention strategies but allow:
  - family and staff to meet for orientation to the program
  - parents/guardians to visit their children.
- Separating children's naptime mats or cribs and place them so that children are spaced out as much as possible and head to toe for sleeping. Face coverings should not be worn when sleeping.
- Providing physical guides, such as wall signs or tape on floors, to help maintain distance between cohorts in common areas.
- Staggering use of communal spaces between cohorts.
- Prioritizing outdoor activities. When possible, physically active play should be done outside. Maintain cohorts if feasible in outdoor play spaces. Face coverings should not be worn when swimming or playing in water.
- Allowing water play, sensory play (such as rice, beans, or playdough activities), and sand play, if physical distancing measures can be maintained. Perform hand hygiene and clean supplies and materials as described in the Cleaning and Hygiene section.
- Allowing outdoor water play using sprinklers, as long as water drains quickly to avoid puddling and is not collected or recirculated.
  - Any structure, chamber, or tank containing an artificial body of water used by the public for swimming, diving, wading, recreation, or therapy, together with buildings, appurtenances, and equipment used in connection with the body of water must be approved and permitted according to the Rules Governing Public Swimming Pools, 15A NCAC 18A .2500.
- Allowing off-premises activities. When off-premises activities occur, the procedures outlined in Child Care Rules 10A NCAC 09 .1005 and .1723; as well as all applicable guidance as described in the Transportation section of this toolkit MUST be followed.

It is also recommended that off-premises activities maintain groups (cohorts) of children and adults AND that the cohorts are not exposed to other groups of children or adults.

Screening and Monitoring for COVID-19

Regular screening and monitoring for symptoms should be done at home, at arrival to child care, and throughout the day to help reduce exposure. The presence of any of the symptoms below generally suggests a person has an infectious illness and should not attend child care, regardless of whether the illness is COVID-19. Ask staff and parents/caregivers to be on the alert for any symptoms of COVID-19 and stay home if they or anyone else in the household is showing any signs of illness or if they have been exposed to COVID-19.

Screening Testing refers to testing done on someone without symptoms or known close contact with someone with COVID-19. Screening testing can be used to help evaluate and adjust prevention strategies and provide added protection for child care staff and children. Screening testing could be offered to all teachers and staff who have not been fully vaccinated. CDC guidance provides that people who are fully vaccinated do not need to participate in screening testing. Screening testing may be most valuable in areas with substantial or high community transmission levels, in areas with low vaccination coverage, and in settings where other prevention strategies are not implemented. Screening testing should be done in a way that ensures the ability to maintain confidentiality of results and privacy of participatings. To be effective, the screening program should test at least once per week, and rapidly (within 24 hours) report results. Screening testing more than once a week might be more effective at interrupting transmission, but feasibility of increased testing in childcare needs to be considered.

For Individuals with:
Symptoms: Children and staff who have symptoms of COVID-19, should stay home and contact their healthcare provider for testing and care. Staying home when sick is essential to keep infections out of child care settings and preventing spread to others.

Diagnosis: People who are presumed to have or are diagnosed with COVID-19 must stay home until they meet the criteria for return to child care. Staying home when sick with COVID-19 is essential to keeping COVID-19 infections out of child care settings and preventing spread to others.

Exposure: It is also essential for people who are not fully vaccinated to quarantine after a recent close contact to someone with COVID-19 symptoms or diagnosed with COVID-19, unless an exception applies.

Child care programs are required to

- Exclude children based on local public health department recommendations for a person who has tested positive for COVID-19 or has been exposed to COVID-19. [Required by NC GS § 130A-144.]
- Immediately notify the local health department if they have reason to suspect that a person within the child care facility has COVID-19. Required by NC GS § 130A-136 and Communicable Disease Rule 10A NCAC 41A .0101 (50-52).
- **Exclude children if**:
    - The child
        - has a fever taken by any method, including at armpit or orally:
            - A child older than two months has a temperature of 101 degrees Fahrenheit or higher.
            - An infant younger than two months has a temperature of 100.4 degrees Fahrenheit or higher.
        - Has two or more episodes of vomiting within a 12-hour period or
        - Has more than two stools above the child's normal pattern and diarrhea is not contained by a diaper or when toilet-trained children are having accidents

- Is unable to participate comfortably in activities.
- Has symptoms that result in a need for care that is greater than the staff members can provide without compromising the health and safety of other children.
[Required by North Carolina Child Care Rules 10A NCAC 09 .0804 and .1720(a).]

Child care programs should:

- Require staff who are not fully vaccinated to be tested weekly for COVID-19
- Have staff perform daily self-monitoring of COVID-19 symptoms before coming to work and stay home if symptomatic
- Have families conduct daily home-based monitoring of symptoms before drop off/check-in and keep children home if symptomatic

- **Exclude staff and children if**:
  - The staff member or child has
    - Fever (temperature of 100.4 degrees Fahrenheit or higher)
    - Chills
    - Shortness of breathing/difficulty breathing
    - New cough
    - New loss of taste or smell
- Have staff monitor for symptoms in staff and children during the day
- Not allow people who report symptoms for COVID-19 to enter a transportation vehicle or the building.

In addition, the presence of any of the symptoms below, suggests the person may need to be tested for COVID-19:

- Sore throat
- Diarrhea
- Nausea/vomiting
- New onset of severe headache, especially with a fever

This list does not include all possible COVID-19 symptoms. Individuals with the virus that causes COVID-19 may experience any, all, or none of these symptoms.

- Immediately isolate a person who develops COVID-19 symptoms during the day while at the facility and send him/her and any family members home as soon as possible.
- While waiting for a child who is sick or has tested positive for COVID-19 to be picked up, have a caregiver stay with the child in a place isolated from others and, if possible, ventilated to outside air.
  - If possible, allowing for air flow throughout the room where the child is waiting by opening windows or doors to the outside.
  - Remaining as far away as safely possible from the child (preferably 6 feet or more) while maintaining visual supervision.
  - Wearing a face covering or a procedure mask and other Personal Protective Equipment including disposable gloves and face shields, if available. If the child is over the age of 2 and can tolerate a face covering, the child should also wear a face covering or a procedure mask, if available. Face coverings should not be placed on:
    - Anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the face covering without assistance or
    - Anyone who cannot tolerate a face covering due to development, medical, or behavioral health needs.
- Ensure that children or staff who become sick during the day do not participate in group transportation to return home.

- When children or staff members have been in close contact with a person that develops symptoms of COVID-19 during the day:
  - Maintain strict cohorting for children and staff who were close contacts with the symptomatic person until a negative COVID-19 test is obtained.
  - Removing children and staff and close off areas used by that person. Wait several hours, if possible, before cleaning and disinfecting. Do not use these areas until after cleaning and disinfecting.

Child care programs could consider:

- Establishing a screening testing program for staff at their facility
- Staggering child arrival, drop-off, and pick-up times or locations by cohort and prioritize outdoor drop-off and pick-up, if possible.
- Allowing one family member to accompany his/her own child(ren) to and from the classroom at drop-off and at pick up, while limiting the amount of time spent in the building, IF the family member:
  - Consistently wears a face covering.
  - Maintains a physical distance of six (6) feet from others at all times.
- Conducting a Health Check each day of the child in the classroom before the parent leaves, to determine whether the child has had any:
  - signs or symptoms of other illness or injury,
  - accidents, unusual events, or injuries,
  - mood or behavior changes.
- Maintaining a dedicated space to isolate people with symptoms who become ill during the day. That space should not be used for other purposes.

Returning to Child Care After Exclusion

Child care programs are required to:

- **Follow the recommendations of the local public health department if someone at the child care facility has tested positive for COVID-19 or has been exposed to COVID-19.** Required by NC GS § 130A-144.

Local public health departments make the final decisions about

- isolation requirements for individuals who test positive for COVID-19
- whether individuals who have been exposed need to quarantine and how long quarantine should last in the communities they serve, based on local conditions and needs.

Quarantine is required for an individual who has been a close contact (within 6 feet for at least 15 minutes cumulatively over a 24-hour period) of someone who is determined positive with COVID-19 either through testing or symptom consistent diagnosis, with the following three exceptions:

- Individuals who are fully vaccinated and do not have symptoms do NOT need to quarantine after a close contact. However, they should get tested 3-5 days after exposure and wear a mask around others until they get a negative test result.
- People who have tested positive for COVID-19 within the past 3 months and recovered and do not have symptoms do NOT have to quarantine.

- Children who are not fully vaccinated after a close contact in a child care setting if masks were being worn appropriately and consistently by both the person with COVID-19 and the potentially exposed person do NOT need to quarantine. This is based on updated CDC guidance and studies that have shown extremely low risk of COVID-19 transmission in classroom settings when face masks were being used appropriately by both the person with COVID-19 and the potentially exposed person, as well as multiple layers of prevention measures in place to prevent transmission in school settings. This exception does not apply to staff or other adults in the indoor child care setting.

Unless an exception applies, the CDC continues to recommend quarantine for 14 days after last exposure.

CDC has offered options to reduce the duration of quarantine, if the local public health department recommends quarantine and allows reduced quarantine. If quarantine is reduced to less than 14 days, the individual must continue to monitor for symptoms daily and strictly adhere to interventions intended to reduce the spread of COVID-19, **including wearing a face covering at all times and practicing physical distancing** until 14 days have past since the date of last exposure.

- If an individual can strictly adhere to interventions to reduce spread, options to reduce the duration of quarantine are available in either of the following two scenarios:
    - 10 days of quarantine have been completed and no symptoms have been reported during daily monitoring;
    - 7 days of quarantine have been completed, no symptoms have been reported during daily monitoring, and the individual has received results of a negative PCR/molecular test on a test taken no earlier than day 5 of quarantine.

Child care facilities should describe their environment (age of children, ability to wear face coverings, physical distancing limitations) to the local health department so that an informed decision about who can be approved for reduced quarantine can be made.

Adhere to the following criteria for allowing a child or staff member to return to child care:

Summary Table for Returning to Child Care

Exclusion Category	Scenario	Criteria to return to child care
Diagnosis	Child/staff person has tested **positive** with an **antigen test** but does **not** have or develop symptoms of COVID-19	If the child/staff person takes a repeat PCR/molecular test performed in a laboratory within 48 hours of their positive antigen test, and that PCR/molecular test is negative: the positive antigen test can be considered a false positive and the person can immediately return to child care; OR If the child/staff person does not take a repeat PCR/molecular test, or takes one within 48 hours and it is also positive, he/she can return to child care when they complete 10 days of isolation. Isolation should begin starting from the date of their first positive test. The person is not required to have documentation of a negative test in order to return to child care.
Diagnosis	Child/staff person has tested **positive** with a **PCR/molecular test** but the person does **not** have and does not develop symptoms.	Child/staff person can return to child care when he/she completes 10 days of isolation. Isolation should begin starting from the date of their first positive test.
Symptoms	Child/staff person **has symptoms** of COVID-19 and has tested **positive** with an **antigen test or PCR/molecular test**	Child/staff person can return to child care when • He/she completes 10 days of isolation. Isolation should begin starting from their first day of symptoms; AND • It has been at least 24 hours since the he/she had a fever (without using fever reducing medicine); AND • Other symptoms of COVID-19 are improving. The person is not required to have documentation of a negative test in order to return to child care.

Symptoms	Child/staff person has symptoms of COVID-19 but has **not** been tested for COVID-19 nor has visited a health care provider. Therefore, the person who has symptoms is presumed positive.	Child/staff person can return to child care when • He/she completes 10 days of isolation. Isolation should begin starting from the first day of symptoms; AND • It has been at least 24 hours since he/she had a fever (without using fever reducing medicine); AND • Other symptoms of COVID-19 are improving.
Symptoms	Person has symptoms of COVID-19 but has received a negative test for COVID-19* or has visited a health care provider and received **an alternate diagnosis** that would explain the symptoms of COVID-19 *In a person with symptoms, a negative test is defined as either (1) a negative PCR/molecular test or (2) a negative antigen test if the person has a low likelihood of SARS-CoV-2 infection (e.g., the person has no known or suspected exposure to a person with COVID-19 within the last 14 days or is fully vaccinated or has had a SARS-CoV-2 infection in the last 3 months.) See CDC antigen algorithm for interpretation of antigen tests	Child/staff person can return to child care when • It has been at least 24 hours since he/she had a fever (without using fever reducing medicine); AND • He/she has felt well for at least 24 hours. Note: The health care provider is not required to detail the specifics of the alternate diagnosis.
Exposure	Child/staff person who is not fully vaccinated has been in **close contact** with someone **with a confirmed case of** COVID-19. (Fully vaccinated persons and persons who have tested positive in the last 3 months and do not have any symptoms after a close contact do not need to quarantine.)	Person can return to child care after completing up to 14 days of quarantine. The 14 days of quarantine begin after the last known close contact with the COVID-19 positive individual. Alternatively the person may complete a **10-day quarantine** if the person i**s not presenting symptoms of COVID-19** after daily at-home monitoring, or they may complete **7 days of quarantine if they report no symptoms during daily at-home monitoring, and the individual has received results of a negative antigen or PCR/molecular test on a test taken no earlier than day 5 of quarantine.** Follow the recommendations of your local public health department if someone at your child care should quarantine. Local public health authorities make the final decisions about how long quarantine should last in the communities they serve, based on local conditions and needs. **If quarantine is discontinued before day 14, the individual should continue to monitor symptoms and strictly adhere to all non-pharmaceutical interventions** (e.g. wear a mask, practice social distancing) through 14 days after the date of last exposure. Note: NCDHHS recommends that childcare not require an individual who is fully vaccinated (at least 2 weeks after getting their second dose in a 2-dose series or one-dose of a single-dose series) or tested positive for COVID-19 in the past three months to quarantine if they have had no symptoms after being a close contact to someone with COVID-19, and they do not live in a congregate setting (such as a shelter).
Exposure	Child who is not fully vaccinated but has been in close contact with someone with a confirmed case of COVID-19, in which both individuals were wearing a mask the entire time. NOTE: This does not apply for adults.	NCDHHS does not recommend quarantine of children following exposures in a child care settings if masks were being worn appropriately and consistently by both the person with COVID-19 and the potential exposed person. This applies to exposures in child care program settings. This option should only be utilized in settings where masks are consistently worn. This exception does not apply to staff, or other adults in the indoor classroom setting.
Household Member, Exposure	Child/staff person is a **household member** (e.g. a sibling) of someone **with a confirmed case of** COVID-19.	Child/staff person can return to child care after completing up to 14 days of quarantine, unless otherwise directed by the local health department. The 14 days of quarantine begin **either**:

		• **at the end** of a 10-day isolation of the person **with** COVID-19 since that person may remain infectious for up to 10 days after symptom onset, **OR** • after the last known close contact with the COVID-19 positive person, in situations where the positive person isolates from all other household members.
Household Member, Symptoms	Child/staff person is a **household member** (e.g. a sibling) of someone who has symptoms of COVID-19 but symptomatic person has **not** been tested for COVID-19, nor has visited a health care provider. Therefore, the person who has symptoms is presumed positive.	Child/staff person can return to child care after completing up to 14 days of quarantine, unless otherwise directed by the local health department. The 14 days of quarantine begin **either**: • **at the end** of a 10-day isolation of the person who is presumed positive **with** COVID-19 since that person may remain infectious for up to 10 days after symptom onset. **OR** • after the last known close contact with the person who is presumed to be COVID-19 positive, in situations where the presumed positive person isolates from all other household members.
Household member, Symptoms	Child/staff person is a **household member** (e.g. a sibling) of someone who has symptoms of COVID-19 and has received a negative test **for COVID-19.** *In a person with symptoms, a negative test is defined as either (1) a negative PCR/molecular test or (2) a negative antigen test if the person has a low likelihood of SARS-CoV-2 infection (e.g., the person has no known or suspected exposure to a person with COVID-19 within the last 14 days or is fully vaccinated or has had a SARS-CoV-2 infection in the last 3 months.) See CDC antigen algorithm for interpretation of antigen tests.	Child/staff person can return to child care immediately, as long as he/she has not developed symptoms.
Household Member, Symptoms	Child/staff person is a **household member** (e.g. a sibling) of someone who has symptoms of COVID-19 but symptomatic person has visited a health care provider and received an **alternate diagnosis** that would explain the symptoms of fever, chills, shortness of breath or difficulty breathing, new cough or new loss of taste or smell, and the health care provider has determined COVID-19 testing is not needed.	Child/staff person can return to child care when symptomatic household member receives their alternate diagnosis, as long as he/she has not developed symptoms. Note: The health care provider is not required to detail the specifics of the alternate diagnosis.

Personal Protective Equipment

Personal Protective Equipment (PPE) protects the person wearing it and those nearby from the spread of germs. When used properly, PPE acts as a barrier between germs found in blood, body fluids, or respiratory secretions and the wearer's skin, mouth, nose, or eyes.

Examples of PPE are:

- Disposable gloves
- Face shields
- Disposable procedural masks

PPE should be used only when necessary and should not be used with healthy children. Disposable PPE should be used in child care by staff who are trained in their use while:

- Waiting with a child who has started showing symptoms of COVID-19 when it is not possible to maintain a distance of six feet

- Completing breathing-related health care procedures, such as nebulizer treatments (see below).

Considerations for children who require asthma treatments

It is uncertain, but possible, that giving nebulizer treatments to children in child care may increase the spread of COVID-19. During the COVID-19 pandemic, asthma treatments using inhalers with spacers should be used whenever possible and nebulizers should be avoided.

During the COVID-19 pandemic, if a child cannot use an inhaler with a spacer, the CDC recommends:

- Only the child and the adult who is helping give the treatment should be in the room where the treatment is being given
- The adult who is giving the treatment should be trained in medication administration, provided with proper PPE (gloves, disposable procedure masks and face shields) and be trained on:
  - when to use PPE
  - what PPE is necessary
  - where the PPE is stored
  - how to properly don (put on) and doff (take off) PPE, and
  - how to properly dispose of used PPE

After the nebulizer treatment, the separate room that was used should undergo cleaning and disinfection.

Face Shields

According to CDC guidance, face shields should not be used as a substitute for face coverings. Face shields protect the wearer's eyes and mask from liquid splashes and sprays. Reusable face shields should be cleaned after each use following the manufacturer's guidelines. If manufacturer guidelines are unavailable, follow CDC guidance.

Cleaning and Hygiene

Requirements and recommendations for Cleaning and Hygiene have been updated to align with guidance from the Center for Disease Control to prevent the spread of COVID-19. Continuing with good hand hygiene practices and routine cleaning/sanitizing/disinfecting routines based on child care and sanitation requirements will prevent the spread of all infectious diseases.

Child care programs are required to:

- **Follow NCDHHS Environmental Health Section guidance for cleaning and disinfection recommendations.**
- **Follow North Carolina Child Care and Sanitation rules.**

Child care programs should:

- **Clean surfaces once a day, prioritizing high touch surfaces.**
- If there has been a sick person or someone who tested positive for COVID-19 within the last 24 hours, clean and disinfect the space using an EPA-approved disinfectant for SARS-CoV-2 (the virus that causes COVID-19).
- **Create a plan for cleaning, sanitizing and disinfecting that protects children and adults.**
  - Develop an internal plan for cleaning, sanitizing, and disinfecting that protects children and adults from both surface contamination and exposure to products.
  - Cleaning products should not be used near children.
  - Staff should ensure that there is adequate ventilation when using cleaning, sanitizing, and disinfecting products to prevent children from inhaling toxic fumes (e.g., open doors and/or windows). Always read and follow the manufacturer's use instructions.

- All cleaning products must be kept secure and out of reach of children in accordance with NC child care and sanitation rules.
- Avoid mixing chemicals. In particular, do not mix bleach with ammonia, acids, or other cleaners, as this can cause serious inhalation hazards and injuries. Be sure to always read the product label before using a cleaning product.
- Remove and not use toys that cannot be easily cleaned.
- Clean all toys that are used consistently:
  - At least weekly, whenever visibly soiled, or as listed below:
  - Mouthed toys or other objects contaminated with oral or respiratory secretions should be removed when a child is finished with them and before another child has access to them. Place these toys in a bin that is inaccessible to other children, then wash hands.
  - In all classrooms, clean and sanitize mouthed toys and contaminated objects between use by individual children in a dishwasher with a sanitizing setting or using the following procedure:
    1. Scrub in warm, soapy water using a brush to reach into crevices.
    2. Rinse in clean water.
    3. Submerge in a sanitizing solution containing 50 to 200 ppm of chlorine for at least two minutes (or sanitize with another approved sanitizing solution) if the toy is submersible. If toy is not submersible, spray the item with sanitizer.
    4. Let air dry.
  - Pacifiers must be reserved for use by one child. Pacifiers that have been observed or suspected to have been shared should be cleaned and sanitized using following procedure:
    1. Scrub in warm, soapy water using a brush to reach into crevices.
    2. Rinse in clean water.
    3. Spray with a sanitizing solution containing 50-200 ppm of chlorine (or sanitize with another approved sanitizing solution).
    4. Wait at least two minutes or the approved contact time for the type of sanitizing solution.
    5. Rinse again to remove sanitizer residue.
    6. Inspect the pacifier for fluid trapped inside. (Discard damaged pacifiers or ones with fluid trapped inside.)
    7. Let air dry.

Child care programs could consider:

- Maintaining awareness of children's behaviors in the classroom in order to remove toys and objects which become contaminated with oral and/or respiratory secretions when the child is finished with it, and clean as described below.

- Minimizing items that are shared between groups/cohorts of children. (Outdoor play equipment is acceptable to share between groups of children.)

- Setting up hand hygiene stations at the entrance of the facility so that people can clean their hands before they enter. If a sink with soap and water is not available, provide hand sanitizer with at least 60 percent alcohol. Keep hand sanitizer out of children's reach and supervise use.
  - Routinely check and refill/replace supplies to support healthy hand hygiene, such as soap, paper towels, tissues, and hand sanitizer with at least 60 percent alcohol for safe use by staff and older children.
  - Teach and reinforce adult and child handwashing with soap and water for at least 20 seconds.
- Encourage people to cough and sneeze into their elbows, or to cover with a tissue, and to avoid touching eyes, nose, and mouth.

For additional recommendations for cleaning and hygiene, see the Center for Disease Control.
- Guidance for Cleaning and Disinfecting in Community, Work and School
- Guidance for Operating Child Care Programs during COVID-19

Transportation

The following guidance should be followed in addition to the NC Child Care Rules .1000 - Transportation Standards. Child care programs leaders should follow the guidelines below and the CDC Transportation Order for their transportation vehicles (e.g., buses, vans).

Child care programs should:

- Require that all children ages 2 years older and all staff, and adult visitors wear face coverings when they are on a bus, van, or other group transportation vehicle, unless the person (or family member, for a child) states that an exception applies. [Required by Center for Disease Control Order.]
- Have staff perform daily self-monitoring of COVID-19 symptoms before boarding group transportation
- Have families conduct daily home-based monitoring of symptoms before children board group transportation.
- Not allow people who report symptoms fo COVID-19 to enter a transportation vehicle.
- Enforce that if an individual becomes sick during the day, they do not use group transportation to return home and follow protocols outlined above.
- Enforce if a driver becomes sick during the day, they follow protocols outlined above and not return to drive students until they meet criteria to return.
- Keep windows open while the vehicle is in motion to help reduce spread of the virus by increasing air circulation, if appropriate, safe, and weather permitting.
- Clean transportation vehicles regularly. Children should not be present when a vehicle is being cleaned.
- Ensure safe and correct use and storage of cleaning and disinfection products, including storing products securely away from children and adequate ventilation when staff use such products.
- Clean frequently touched surfaces in the vehicle (e.g., surfaces in the driver's cockpit, hard seats, arm rests, door handles, seat belt buckles, light and air controls, doors and windows, and grab handles) prior to morning routes and prior to afternoon routes.
- Keep doors and windows open when cleaning the vehicle and between trips to let the vehicles thoroughly air out.
- Clean equipment including items such as car seats and seat belts, wheelchairs, walkers, and adaptive equipment being transported to schools.
- Create a plan for getting sick students home safely if they are not allowed to board the vehicle.
- Provide hand sanitizer (with at least 60% alcohol) to support healthy hygiene behaviors on all school transportation vehicles for safe use by staff and older children.
    - Hand sanitizer should only remain on school transportation while the vehicles are in use.
    - Systematically and frequently check and refill hand sanitizers.

Child care programs could consider:

- In transport vehicles, seating one child per row or skip rows when possible. Children from the same home can sit together.

Ventilation and Water Systems

Improving ventilation is an important COVID-19 prevention strategy that can reduce the number of virus particles in the air. 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.

Ensure ventilation systems operate properly and increase circulation of outdoor air as much as possible by opening screened windows and doors, using fans, or other methods. Do not open windows and doors if they pose a safety or health risk to people using the facility. During transportation, open or crack windows in buses and other forms of transportation, if doing so does not pose a safety risk.

Check for hazards such as mold, Legionella (bacteria that causes Legionnaires' disease), and lead and copper contamination from plumbing that has corroded after reduced operation or temporary building shutdown.

For more specific information about maintenance, use of ventilation equipment or plumbing, actions to improve ventilation and reduce hazards, consult with your local Environmental Health Specialist or refer to CDC guidance:

- Ventilation in Schools and Child Care Programs
- Ventilation FAQs
- Improving Ventilation in Your Home

Resources

- NCDHHS: COVID-19: Individuals and Families
- NCDHHS: Coping and Resilience
    - For child care staff – Hope4Healers or 919-226-2002
    - For families – Hope4NC or 1-855-587-3463
- NC Child Care Health and Safety Resource Center: Child Care Health Consultant Network
- Local Health Departments: Contact Information by County
- NCDHHS: Interim Guidance for Safe Application of Disinfectants
- CDC: Guidance for Operating Child Care Programs during COVID-19
- CDC: People at Increased Risk
- CDC: Cleaning and Disinfecting Your Facility
- CDC: How to Protect Yourself and Others
- CDC: Coping with Stress
- CDC: For Facilities Planning to Reopen After Extended Closure
- EPA: Disinfectants for Use Against SARS-CoV-2
- FDA: Food Safety and the Coronavirus Disease 2019 (COVID-19)
- HHS/OSHA: Guidance on Preparing Workplaces for COVID-19

Glossary

Antigen Test: Rapid antigen tests, which detect protein on the surface of the virus, are less sensitive and less specific than a PCR/molecular test. This means they miss some infections that would be detected by a

PCR/molecular test, and they may be positive in someone who does not actually have the infection. However, they can be performed without having to send the sample to a laboratory and results come back quickly (eg., approximately 15 minutes). For this test, a sample may be collected through a nasal swab, and the test can be conducted inside a doctor's office, or even at a community event that meets the right set of requirements.

Asymptomatic: Not showing any symptoms (signs of disease or illness). Some people without any symptoms still have and can spread the coronavirus. They're asymptomatic, but contagious.

Close Contact: Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before symptoms began (or, for asymptomatic individuals, 2 days prior to test specimen collection date) until the time the individual is isolated.

Cluster: Five or more positive COVID-19 cases in a setting within 14 days of one another, that have an epidemiological linkage between them (e.g., presumed COVID-19 transmission within a child care classroom.) Note: An "outbreak" is a specific term used for a congregate living setting, such as a nursing home, when there are two or more cases connected to each other. A cluster and an outbreak are not the same thing.

Cohort: A group of non-overlapping children, teachers and staff who are designated to follow identical schedules. Keeping clear and distinct schedules helps with contract tracing, should it be necessary.

Communicable: Similar in meaning as "contagious." Used to describe diseases that can be spread or transmitted from one person to another.

Community Spread: The spread of an illness within a location, like a neighborhood or town. During community spread, there's no clear source of contact or infection.

Confirmed Case: Someone tested and confirmed to have COVID-19.

Coronavirus: A family of related viruses. Many of them cause respiratory illnesses. Coronaviruses cause COVID-19, SARS, MERS, and other respiratory illness. The coronavirus that causes COVID-19 is officially called SARS-CoV-2, which stands for severe acute respiratory syndrome coronavirus 2.

COVID-19: The name of the illness caused by the coronavirus SARS-CoV-2. COVID-19 stands for "coronavirus disease 2019."

Exclusion: An individual is not allowed to attend child **care** in person in order to isolate because they are, or are presumed to be, COVID-positive, or to quarantine to ensure they do not expose others if they may become COVID-positive.

Exposure: Being within 6 feet of someone diagnosed with COVID-19 for a cumulative total of 15 minutes or more, over a 24-hour period.

Fully Vaccinated: People are considered fully vaccinated:
- 2 weeks after their second dose in a 2-dose series, like the Pfizer or Moderna vaccines, or
- 2 weeks after a single-dose vaccine, like Johnson & Johnson's Janssen vaccine

Incubation Period: The time it takes for someone with an infection to start showing symptoms. For COVID-19, symptoms appear 2-14 days after infection.

Isolation: When someone tests positive for COVID-19 or is presumed to be positive, they separate (isolate) themselves from others for 10 days to make sure they do not spread the virus. This is not the same thing as quarantining, which is for someone who is NOT positive with COVID.

Local Health Department: An administrative or service unit of local or state government concerned with health and carrying out some responsibility for the health of a jurisdiction smaller than the state.

Off-premises Activities: Any activity that takes place away from the child care premises (defined as: the entire child care building and grounds including natural areas, outbuildings, dwellings, vehicles, parking lots, driveways and other structures located on the property).

PCR/molecular Testing: Polymerase chain reaction (PCR)/ molecular tests detect the virus's genetic material. This test is the "gold standard" for detecting the virus that causes COVID-19 and typically requires a sample being sent to a laboratory. For this test, it is most common that samples are collected through a nasal swab.

Pandemic: When a new disease spreads to many countries around the world.

PPE: PPE stands for personal protective equipment. This includes masks, face shields, gloves, gowns and other coverings that help prevent the spread of infection to the wearer.

Physical Distancing: Consistently putting space between yourself and other people. The goal is to slow down how fast an infection spreads. The CDC recommends keeping at least six feet between you and others around you in public. Physical distancing also includes avoiding crowds and groups in public.

Presumptive Positive Case: A person who has COVID-19 symptoms but has not been confirmed positive by a health care provider or through a laboratory test.

Positive COVID-19 Test: An individual has taken a PCR/molecular COVID-19 test or an antigen COVID-19 test and the result is positive.

Quarantine: Quarantine refers to the time spent away from other people by an individual who has been in close contact (within 6 feet for at least 15 minutes cumulatively over a 24-hour period) with someone who is positive with COVID-19. A person exposed to

COVID-19 may quarantine for up to 14 days - the incubation period of the virus. This is not the same thing as isolation, which is for someone who is positive with COVID-19.

Symptom Screening: A series of basic questions about a person's health condition and recent potential exposure to someone who has had COVID-19. This is not the same thing as a COVID-19 test.

Symptomatic: When a person shows signs of illness. For COVID-19, that includes new cough, fever, shortness of breath, or new loss of taste or smell.

Testing: Testing is used to track cases of COVID-19 in the population. Anyone with COVID-19 symptoms, those who have been around others with symptoms or others who have tested positively, and high-risk members of the population should consider testing for COVID-19. The most common tests are the molecular PCR test and the antigen test, both of which seek to determine whether or not a person currently is infected with COVID-19. The NCDHHS hosts testing sites regularly throughout the state.