Maryland

DEPARTMENT OF HEALTH
*Dennis R. Schrader, Secretary*

STATE DEPARTMENT OF EDUCATION
*Mohammed Choudhury, Superintendent*

# K-12 School and Child Care COVID-19 Guidance

Revised August 13, 2021

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 determine 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.

## A. 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 elementary schools and child care programs primarily serve children under age 12 years who are not yet eligible for vaccination. This makes it critical that schools and child care programs work with local health departments to determine 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 under 12 years), it is even more important that other strategies such as consistent and correct mask use and physical distancing be utilized.

## B. 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.

### C. Consistent and Correct Mask Use

**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.

### D. 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 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.

## E. Screening Testing

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 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. The use of diagnostic testing in the school setting should also be considered; 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 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.

## F. 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 strongly recommends 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.

## G. When to Stay Home and Get Tested

It is important for schools and child care programs to stress and reinforce frequently 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 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; 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.

## H. Contact Tracing in Combination with Isolation and Quarantine

Local school systems, nonpublic schools, and child care programs should continue to 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.

***Isolation***

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

***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.

Close contacts who are not fully vaccinated should not attend, work in or visit a school or child care program until completing quarantine. A quarantine period of 14 days remains the safest option for close contacts of persons with COVID-19 who are not fully vaccinated. Based on guidance from the CDC, the following options to shorten quarantine may be an acceptable alternative 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.

Note: 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 must quarantine for a full 14 days.

Fully vaccinated persons who have come into close contact with someone with COVID-19 should be tested 3-5 days following the date of their last exposure and wear a mask in public indoor settings for 14 days or until they receive a negative test result. If they remain asymptomatic and can correctly and consistently wear a mask, they do not need to be excluded from school or child care unless they test positive.

Schools should note the important exception to the CDC's close contact definition specifically for K-12 schools, which states that students who were within 3 to 6 feet of an infected student (if both the infected student and the exposed student correctly and consistently wore well-fitting masks the entire time) do not have to quarantine. MDH and MSDE recommend that schools consider application of this exception in the school setting as it can decrease student and staff absences due to the need to quarantine after an exposure in school.

Local school systems, nonpublic schools, and child care programs should refer to CDC guidance for additional recommendations regarding quarantine of close contacts and work with their local health departments to determine the appropriate quarantine options for their population of students/children, teachers, and staff.

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**Response to a Confirmed Case of COVID-19 and Persons with COVID-19 Symptoms in Schools and Child Care**
August 13, 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 make it clear that the contact should expect a call from health department contact tracers. The notification may also include the following information:

- When to seek medical care
- How to monitor for symptoms
- Who to contact and how to contact them if they develop symptoms of COVID-19 while under quarantine
- The projected length of quarantine if they remain asymptomatic based on MDH and local quarantine guidance
- Information about local COVID-19 testing sites.

**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 to this document);
- 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 classroom or school/child care program closure and recommendations for COVID-19 testing of staff and students/children will be made by the LHD.

# 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<br><br>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 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. | All close contacts should quarantine according to MDH and local guidance *except* those who are fully vaccinated[2] OR have been infected with COVID-19 in the past 90 days AND are asymptomatic. |
| 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.<br><br>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.<br><br>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. | Household members[3] should not attend or work in a child care, school, or youth camp until the person with symptoms is able to return *except* those who are fully vaccinated OR have been infected with COVID-19 in the past 90 days AND are asymptomatic. |
| | 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. | All close contacts should quarantine according to MDH and local guidance *except* those who are fully vaccinated[2] OR have been infected with COVID-19 in the past 90 days AND are asymptomatic. |

[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.
[3]These persons should not be reported to the local health department as contacts. The child care, school, or youth camp should inform the household members of these recommendations.

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

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| **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<br><br>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 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. | All close contacts should quarantine according to MDH and local guidance *except* those who are fully vaccinated[2] OR have been infected with COVID-19 in the past 90 days AND are asymptomatic. |
| 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. | All close contacts should quarantine according to MDH and local guidance *except* those who are fully vaccinated[2] OR have been infected with COVID-19 in the past 90 days AND are asymptomatic. |

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