



DISTRICT OF COLUMBIA

OFFICE OF THE STATE SUPERINTENDENT OF

**EDUCATION**

## **Frequently Asked Questions (FAQ)**

### **Supporting Document for *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period***

(Dec. 21, 2020)

The Office of the State Superintendent of Education (OSSE) issued updated guidance on Dec. 21, 2020 for District of Columbia child care providers during the recovery period from the coronavirus (COVID-19) public health emergency, available [here](#). The *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period* includes guidance for child care providers from the District of Columbia Department of Health (DC Health) and recommendations from the Centers for Disease Control and Prevention (CDC).

#### **Scope**

This document is intended to address frequently asked questions related to child care providers' implementation of the *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period*. Additional and less-common questions are answered during (and in follow-up notes to) the biweekly COVID-19 technical assistance calls. Contact [OSSE.DELcommunications@dc.gov](mailto:OSSE.DELcommunications@dc.gov) for more information or to register for these biweekly COVID-19 technical assistance calls for child care providers.

#### **Effective Date**

This document was updated on Dec. 21, 2020. OSSE will continue to update this document over time.

For information and resources on the District of Columbia Government's COVID-19 response and recovery effort, please visit [coronavirus.dc.gov](https://coronavirus.dc.gov). The CDC's most recent, supplemental guidance for child care can be accessed [here](#). OSSE COVID-19 guidance and resources are available [here](#).

If you have questions relating to this guidance, submit your questions to [OSSE.DELcommunications@dc.gov](mailto:OSSE.DELcommunications@dc.gov).

## TABLE OF CONTENTS

|  |    |
|--|----|
| COMMUNICATION WITH STAFF AND FAMILIES .....  | 3  |
| VACCINES AND HEALTH FORMS <i>[UPDATED]</i> .....                                       | 3  |
| REOPENING AND MAINTAINING BUILDINGS <i>[UPDATED]</i> .....                             | 4  |
| PHYSICAL (SOCIAL) DISTANCING <i>[UPDATED]</i> .....                                    | 5  |
| DAILY HEALTH SCREENING <i>[UPDATED]</i> .....  | 9  |
| NON-MEDICAL (CLOTH) FACE COVERINGS <i>[UPDATED]</i> .....                              | 12 |
| HYGIENE <i>[UPDATED]</i> .....   | 15 |
| CLEANING, DISINFECTION, AND SANITIZATION <i>[UPDATED]</i> .....                        | 16 |
| HIGH-RISK INDIVIDUALS <i>[UPDATED]</i> .....   | 18 |
| MEALS <i>[UPDATED]</i> .....   | 19 |
| EXCLUSION, DISMISSAL, AND RETURN TO CARE CRITERIA AND PROTOCOLS <i>[UPDATED]</i> ..... | 19 |
| EXPOSURE REPORTING, NOTIFICATIONS, & DISINFECTION <i>[UPDATED]</i> .....               | 21 |
| GENERAL QUESTIONS .....  | 23 |

## COMMUNICATION WITH STAFF AND FAMILIES

(For more information, see *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section A. Communication with Staff and Families*)

### 1. How will staff be made aware of COVID-19 policies and safety measures?

To support clear communication with children, staff, and families, child care facilities must post [signs](#) in highly visible locations (e.g., facility entrances, restrooms) that [promote everyday protective measures](#) and describe how to [stop the spread of germs](#) (such as by [properly washing hands](#) and [properly wearing a cloth face covering](#)). At a minimum, child care providers must place signage in every classroom and near every sink reminding staff of hand-washing protocols and in every classroom reminding staff of cleaning protocols.

Facilities should include messages about behaviors that prevent the spread of COVID-19 when communicating with staff and families (such as on child care provider websites, in emails, and on [social media accounts](#)). They should also educate staff, children and families about COVID-19, physical (social) distancing, when they must stay home, and when they can return to child care. Additionally, they should educate staff on COVID-19 prevention and response protocols.

### 2. How will families be made aware of COVID-19 policies and safety measures?

The *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period* was updated Dec. 11, 2020 and is posted [here](#). Providers should inform families that the guidance exists and provide them with the link so they may access the guidance on their own.

Additionally, OSSE has developed two family-friendly flyers to help inform the public of what to expect when their children return to the child care setting. They are designed to provide families with reassurance and also reinforce the new health and safety measures that have been put in place. The two flyers are entitled “What to Expect at Your Child Care Provider During COVID-19” and “Child Care Safety During COVID-19.” These flyers (and any other future OSSE family-friendly materials) will be made available at OSSE’s coronavirus webpage located [here](#).

## VACCINES AND HEALTH FORMS [UPDATED]

(For more information, see *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section B. Vaccines and Health Forms*)

### 1. Families are reporting difficulty in getting to the doctor. Are there any extensions for vaccines, physical exams, or oral health exams? [UPDATED]

For children age 3 and older, OSSE authorized a 90-day extension to submit Universal Health Certificates (UHCs), Oral Health Assessments (OHAs), and Medication and Treatment Authorization forms. **This extension was effective through Nov. 2, 2020 for UHCs and Medication and Treatment Authorization forms and is effective through Jan. 31, 2021 for OHAs.** Child care providers must now collect timely, unexpired Universal Health Certificates (UHCs) from all infants, toddlers, and children in accordance with District law and regulation. Both old and new versions of the health forms shall be accepted. Partial UHCs completed via telehealth visits shall be accepted.

Please note: There is no extension for vaccinations. All children enrolled in child care, unless meeting a medical or religious exemption, are to continue to receive all vaccines as required by District law and regulation. Children may continue to receive fully virtual (or distance learning) services while out of compliance with vaccines, but may not return for in-person services or activities until the vaccine requirements are met.

## **2. What resources are available to support child care centers and families with vaccination compliance? [UPDATED]**

To prevent a vaccine-preventable disease outbreak in a child care setting, it is imperative for all children who attend child care be **fully vaccinated** according to CDC and DC Health standards. Child care centers should ensure that a policy is in place to adhere to all OSSE licensing standards regarding vaccines (immunizations). Resources include:

- A review of vaccine requirements can be found [here](#) and health forms can be found [here](#).
- A list of pediatric vaccine locations can be found [here](#). A search tool to find a primary care center in DC can be found [here](#).
- Toolkits from the CDC for promoting vaccines with your families can be found [here](#).
- More information from the CDC regarding an eventual COVID-19 vaccine can be found [here](#).

## **REOPENING AND MAINTAINING BUILDINGS [UPDATED]**

*(For more information, see Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section C. Reopening and Maintaining Buildings)*

### **1. Should child care facilities continue to conduct fire drills during the recovery period? [UPDATED]**

At this time the DC Fire and EMS Fire Marshal is recommending that the physical evacuation of buildings for drill purposes as required by the fire code be postponed temporarily through March 31, 2021. This is to prevent the large gathering of people congregating in designated assembly areas during a non-emergency situation.

During this temporary postponement period, the Fire Marshal is encouraging the use of other methods by workplace safety coordinators and managers that will reinforce building evacuation awareness for employees. Some examples include: communications on office noticeboards, emailing out procedures and evacuation plans together with a risk-based approach being adopted for employees, video presentations, and in-person evacuation procedure reviews directly with employees (while practicing 6 feet social distancing).

### **2. If a child care facility is reopening, how should they notify OSSE of the program's planned reopening date?**

Child care facilities must submit an [Unusual Incident Report](#) (UIR) to notify OSSE of the program's planned reopening date. The reopening UIR must be sent to [OSSE.childcarecomplaints@dc.gov](mailto:OSSE.childcarecomplaints@dc.gov) and is to be sent as soon as the reopen date is set. When sending the UIR, indicate the planned date for reopening in the description and details section of the UIR.

### **3. What must facilities do to ensure ventilation (HVAC) and water systems are safe as they reopen after a prolonged shutdown? [NEW]**

Child care providers who are reopening after a prolonged facility shutdown must ensure all ventilation and water systems and features (e.g., sink faucets, drinking fountains) are safe to use and are adequately maintained throughout the operating period. Providers must flush water systems to clear out stagnant water and replace with fresh water, following specific [CDC guidance](#). It may be necessary to conduct ongoing regular flushing after reopening. For additional resources, refer to EPA's Information on Maintaining or Restoring Water Quality in Buildings with Low or No Use.

Child care providers must ensure ventilation systems operate properly, including inspecting and routinely replacing HVAC filters and ensuring that all HVAC system components and exhaust fans, if applicable, are operable to design. They should also consider ventilation system upgrades or improvements and other steps to increase the delivery of clean air and dilute potential contaminants in the facility. In consultation with an experienced HVAC professional, child care providers should review and implement as appropriate additional recommendations from the CDC, the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) Guidance for Building Operations During the COVID-19 Pandemic, and ASHRAE guidelines for schools and universities, which includes further information on ventilation recommendations for different types of buildings.

Child care providers should also increase circulation of outdoor air as much as possible, for example by opening windows and doors or using fans near open windows. Do not open windows and doors if doing so poses a safety or health risk (e.g., risk of falling, triggering asthma symptoms). Under **no circumstances** may fire-rated doors be left open.

## **PHYSICAL (SOCIAL) DISTANCING [UPDATED]**

*(For more information, see Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section D. Physical (Social) Distancing)*

### **1. Why is it important to keep the same groups of children and staff together? [UPDATED]**

Keeping the same group of children and staff together minimizes the risk of transmission to other groups of children receiving care in the same facility. Additionally, if a child or staff member becomes ill, the provider, parents and DC Health can more easily determine which children and staff may have been exposed. To prevent the spread of COVID-19, there must be no mixing between or combining of groups, including during entry and exit of the building, at meal time, in the restroom, on the playground, in the hallway, and in other shared spaces.

In accordance with [Mayor's Order 2020-119](#), families should also be encouraged to not mix with large groups while outside of child care, including at parties, restaurants, public or private gatherings, and public playgrounds. Outdoor mass gatherings may not exceed 25 individuals and indoor private gatherings may not exceed 10 individuals. These group-size limits apply to individuals when outside of school and child care.

**2. What are the allowable group sizes for child care to ensure appropriate physical distancing? [UPDATED]**

**For infants, toddlers, preschoolers, and school-aged children:** No more than 12 individuals (staff and children) clustered in one group. One additional adult (13 total individuals) can briefly be added to the group if necessary.

- Child care providers must continue to adhere to maximum group sizes and staff-to-child ratios per OSSE licensing guidelines Section 121.
- For indoor activities, this means no more than 12 (or, briefly, 13) individuals in one group.
- For outdoor activities, each group of 12 (or, briefly, 13) individuals must interact only with their own group and not mix between other groups. Each group must have extra social distance (more than 6 feet) between them and the next group.

While there is no set amount of time that the additional 13<sup>th</sup> person may “briefly” be in the group, they should only be in the group as long as necessary to complete their prescribed tasks.

**3. Can floaters be used to provide teachers breaks? [UPDATED]**

A relief teacher, or floater, will be allowed to enter a classroom to provide breaks or serve as runner, as long as the total individuals (staff and children) in the group does not exceed 12 (or briefly 13) individuals. **All floating staff, runners, substitutes, essential visitors and any adults briefly joining a classroom should be strictly limited to the maximum extent feasible and only used when necessary.** Floating staff members should **not attend to more than two classrooms or cohorts per day.** Floating staff may be allowed to briefly visit a classroom **only when they:** meet the non-medical (cloth) face covering criteria as listed in section F of the *Health and Safety Guidance for Child care Providers*, wash their hands prior to entry and exit of the room; wear a clean smock (e.g., gown/coverall)<sup>1</sup> over their clothes; and place booties over their shoes as used for infant classrooms (note: smocks and booties worn by runners do not need to be changed between entering each classroom unless they come into contact with secretions). Substitutes are allowable if necessary, and must follow provisions above for floating staff members. If DC Health identifies concerns with floating staff members through a contact tracing investigation, a complaint may be filed to OSSE to investigate, and if inappropriate floating staff use was identified, OSSE may close the facility until the facility remediates.

**4. Is it ever allowable to have additional individuals in a group of adults and children? [UPDATED]**

When necessary (e.g., one-on-one therapy per a child’s IFSP or IEP) there is an allowance for brief periods of one additional adult per group (for a total of 13 people). Such therapists must follow the same set of precautions as listed for floaters including wearing a non-medical (cloth) face covering, smock (e.g., gown/coverall)<sup>2</sup> and booties, and washing (or sanitizing) their hands before and after the session. To the extent feasible, the therapist and child should move to a corner of the room as far from other individuals as possible. **All floating staff, runners, substitutes, essential visitors and any adults briefly joining a classroom should be strictly limited to the maximum extent feasible and used only when necessary. These staff should not visit more than two classrooms or cohorts**

---

<sup>1</sup> The coverall may be a large, button-down, long-sleeved shirt.

<sup>2</sup> The coverall may be a large, button-down, long-sleeved shirt.

**per day.** Non-essential visitors to the classroom (such as extracurricular teachers) should **not** be permitted at this time.

**5. Can more than one group share a classroom if there is space between the groups?**

More than one group may occupy a classroom *if the below provisions (and additional required physical distancing measures including maximum group sizes shared in #2 above) are followed:*

- Child care providers may use partitions to separate groups;
- Partitions must be at least six feet tall and of solid material with no holes or gaps (e.g., solid barrier or fire-resistant vinyl blankets);
- Individuals must be at least 6 feet away from the partition on each side;
- To effectively create a barrier, the 6-foot-tall partition must extend the length of the area in which children and staff are using for activities. No classroom activities should occur outside the barrier of the partition. The open space at each end of the partition *may not* be used to congregate but may function as a hallway to be used with appropriate social distancing measures.
- Partitions must align with regulatory safety protocols to ensure they are not fall hazards, allow for proper ventilation, meet fire safety regulations, and meet any other safety regulations. The regulatory and safety protocols for partitions are detailed in guidance issued by The Department of Consumer and Regulatory Affairs (DCRA) which can be accessed [here](#).

Providers with questions about partitions, including questions about vendors, can contact DC Child Care Connections at (202) 829-2500 or [osse.dchildcareconnections@dc.gov](mailto:osse.dchildcareconnections@dc.gov), or visit the resources website from DC Child Care Connections [here](#).

**6. If group sizes are followed per the guidance, is there any change to adult-to-child ratios?**

**[UPDATED]**

No. Adult-to-child ratios are to be maintained. In accordance with OSSE Licensing subsection 121.8, Child Development Centers shall have at least two staff members supervising children at all times regardless of the group size of the children.

**7. During naptime, what strategy should be used to promote social distancing?**

At naptime, ensure that children are spaced out as much as possible. Nap mats, cots, and cribs must be placed head to toe, where *head to head distance* is at least 6 feet apart. During naptime, face coverings **should not** be worn by children.

**8. Are there any suggestions for how to physically (social) distance with young children?**

Navigating physical (social) distancing standards and the evolving changes in daily life can be challenging for children and their parents and caregivers.

In the child care facility, approaches to support physical (social) distancing include:

- Physically rearrange the room to create “play hubs” in support of individual play:
  - Set up indoor and outdoor settings to maximize spacing (six feet at minimum) between individuals, including while at tables and in group and individual activities;

- Set up individual activity stations (e.g., art, puzzles, reading). This can support distance between children and to limit item sharing. To the extent possible, the individual activity stations should include children’s own set of supplies or a rotation of supplies that are cleaned and sanitized, per the health and safety guidance, between each child’s use.
- Review the daily schedule and modify to create a “for now” routine. Children (and adults) benefit from a predictable routine and while some things may need to change having those changes be consistent from day to day can help create stability. This could include:
  - Identifying large group activities that have children sitting or standing close together and modify or replace with a “for now” activity to create distance between children.
  - Implement small group activities and encourage individual play/activities. For example, if the class has ten children, break into two small groups, and designate space in the classroom for individual play. In infant classrooms, keep the non-mobile infants separate from the mobile infants and implement small group, focused activities with this group.
- Incorporate developmentally appropriate discussions that help children understand why they need to keep a physical distance and understand what is happening around them. Some resources that may be helpful are:
  - Child Mind Institute: [Talking to Kids About Coronavirus](#)
  - PBS: [How to Talk to Kids About Coronavirus](#)
  - Brains on! [Understanding coronavirus and how germs spread](#)
  - [Sesame Street in Communities: Comfort Strategies](#)
  - Conscious Discipline: [Masks and Gloves Social Story](#) (you’ll need to sign-up for a free membership to access this resource)
  - The CDC created recommendations to help adults have conversations with children about COVID-19 and ways to avoid getting and spreading the disease, which can be found [here](#).
  - The National Association of School Psychologists offers recommendations for help children of all age groups to reduce risk, feel supported and reduce stress, which can be found [here](#).
  - The American Academy of Pediatrics offers recommendations for navigating physical (social) distancing measures with children and teens through outdoor activity [here](#).
- Implement a lane system in hallways, stairwells, and other common areas.
- Install physical barriers, such as sneeze guards and partitions, particularly in areas in which it is difficult for individuals to remain six feet apart (e.g., reception areas, between bathroom sinks, etc.)

**9. With physical (social) distancing in place, how can we console a crying or hurt child or appropriately take care of infants?**

- Infants, toddlers, and children who are crying or hurt should still be held and comforted throughout the day.
- Because providers will continue to come into close contact with infants and young children needing comfort, extra precautions must be taken when providing care to this age range.
- OSSE’s health and safety guidance includes specific provisions for staff to most safely console a crying or hurt child, as reiterated in the guidance from CDC. While washing,



feeding or holding infants and very young children, staff should take additional precautions by:

- Wear a non-medical (cloth) face covering;
  - Pull long hair off of neck, as in a ponytail;
  - Wear a smock (e.g., gown/coverall) which may be a large, button-down, long-sleeved shirt;
  - Remove and wash their clothing and/or the child's clothing if touched by any secretions; and
  - Wash their hands, arms or body if touched by secretions or after handling soiled clothes.
- Additional PPE requirements for educators and staff in close contact with children, and/or working with any individual with suspected or confirmed COVID-19, are articulated in Appendix B.

**10. Are workers, contractors, and inspectors allowed to come into the child care facility? [NEW]**

Yes. Essential visitors (e.g., maintenance workers, inspectors) are allowable, but must complete the daily health screening, wear a face covering, maintain physical distancing to the extent feasible, and practice proper hygiene. Child care providers should limit non-essential visitors (e.g., prohibit outside visitors from entering the school unless their presence was requested or if they received permission to enter the school).

## DAILY HEALTH SCREENING [UPDATED]

*(For more information, see Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section E. Daily Health Screening)*

**1. Does OSSE have a tool that child care providers can use to screen children and staff for symptoms upon arrival? [UPDATED]**

Yes. OSSE developed sample daily screening trackers for [children and staff](#). Child care providers are not required to use these trackers, and do not need to submit results to OSSE. However, providers may use these trackers each day to properly screen for symptoms and document which children, staff and essential visitors completed the screen.

Results of the daily screening must be reviewed routinely. Records of screening are strongly recommended to be stored for 30 days to share with DC Health for contact tracing purposes should an incident occur.

Any individual reporting symptoms, possible exposure, or is awaiting test results must not be allowed entry.

**2. Is a daily temperature check a required component of the health screen? [UPDATED]**

Temperature checks at the facility as a screening tool are not recommended by DC Health. Child care providers that choose to implement a physical temperature check must follow appropriate protocols per Section E and Appendix A of the Health and Safety Guidance. Please see question 3 of this section below for more information.

### 3. What protocols should be in place if my staff is checking an individual's temperature?

Temperature checks at the facility as a screening tool are not recommended by DC Health. Child care providers that choose to implement a physical temperature check should adhere to the following guidance:

**At-home check:** Where feasible, providers may ask staff or essential visitors to check their own temperatures, and parents/guardians to check their child's temperature, two hours or less before arrival to the child care site. Upon arrival, the parent/guardian, staff member or visitor should show a photograph of the thermometer or verbally confirm that the temperature was less than 100.4 degrees Fahrenheit. This option eliminates the need for supplies, risk to screeners, and congregation of individuals while waiting to complete the temperature check upon arrival.

**On-site check:** If providers ask for a temperature check upon arrival, the parent/guardian, staff member or essential visitors are to use a thermometer provided by the child care provider and must follow the protocols found in the Daily Health Screen (Section E) of the child care health and safety guidance.

In the event a staff member must take an individual's temperature at the facility, the staff member must follow CDC guidance to do so safely including with use of a barrier protection or Personal Protection Equipment (PPE), as articulated in Appendices A and B of *Health and Safety Guidance for Child Care Providers: Covid-19 Recovery Period*. The use of non-contact thermometers is strongly recommended. Forehead, tympanic (ear), or axillary (armpit) temperature checks are also acceptable. Thermometers must be cleaned thoroughly before and after each use per manufacturer instructions.

### 4. Under what criteria should a child or staff be excluded? [UPDATED]

Children, staff and essential visitors must stay home, or not be admitted, if:

- The child, staff member or essential visitor has experienced one or more of the following symptoms. (Section E of the *Health and Safety Guidance for Child Care Providers* shares additional information on how to conduct a daily health screening).
  - Fever (subjective or 100.4 degrees Fahrenheit) or chills
  - Cough
  - Congestion or runny nose<sup>3</sup>
  - Sore throat
  - Shortness of breath or difficulty breathing
  - Diarrhea
  - Nausea or vomiting
  - Fatigue
  - Headache
  - Muscle or body aches
  - Poor feeding or poor appetite
  - New loss of taste or smell

---

<sup>3</sup> If the runny nose is circumstantial (e.g., after playing outdoors in cold weather) and temporary (subsides within 30 minutes), and the individual is not experiencing other COVID-19 symptoms nor other criteria for exclusion, the individual does not need to be excluded.

- Or any other symptom of not feeling well.
- The child, staff member, essential visitor or any close contact is confirmed to have COVID-19.
- The child, staff member or essential visitor is awaiting COVID-19 test results.

The individual has traveled in the past 14 days to a high-risk state, or a high-risk country or territory unless they have obtained a negative COVID-19 PCR test at least three to five days after their return.

If excluded, parents/guardians, staff and essential visitors should call their healthcare provider for further directions. Please reference the Exclusion, Dismissal and Return to Care criteria of the guidance (Section K) for information on what parameters must be met for a child or staff member to return to care.

**5. For children and staff with chronic health conditions who experience symptoms similar to COVID-19 (e.g. a child with asthma with a cough after exercise), should child care providers exclude them due to symptoms? If not, what documentation do providers need in place to allow them entry?**

If a child or staff member has a pre-existing health condition that presents with specific COVID-19 like symptoms but those symptoms were evaluated by a health care provider and determined to be not COVID-19, that child or staff member should not be excluded from the building on the basis of those specific symptoms.

In such circumstances, the child or staff member should have their health care provider provide verbal or written documentation to the child care provider of the specific symptoms that are related to the chronic health condition and for which the child or staff member do not need to be excluded. This documentation can be in the form of a phone call, fax, email or written note from the health care provider. Parental or staff self-reporting, in the absence of documentation from a health care provider, is insufficient.

**6. How should facilities navigate cold weather, when children may get a runny nose after outdoor activity such as walking to child care or returning indoors from recess? [NEW]**

If the runny nose is circumstantial (e.g., after walking to school or playing outdoors in cold weather) and temporary (subsides within 30 minutes), and the child is not experiencing other COVID-19 symptoms nor other criteria for exclusion, the child does not need to be excluded.

**7. How does the Mayor’s travel order impact child care facilities? [NEW]**

In accordance with [Mayor’s Order 2020-110](#), individuals who have traveled to any place other than the District, Maryland, Virginia or a low-risk state, country or territory must either:

- (1) Self-monitor and limit daily activities—including not attending child care—for 14 days, or
- (2) Self-monitor and limit daily activities—including not attending child care—for at least 3-5 days and then receive a negative COVID-19 PCR test before returning to child care.

Low-risk states will be posted by DC Health on [coronavirus.dc.gov/phasetwo](https://coronavirus.dc.gov/phasetwo). The CDC website contains a [list of countries and territories by risk-level](#). Individuals who have traveled to countries or territories with Level 3 risk are subject to the Mayor’s Order travel restrictions after return to the District, as outlined above.

Child care providers may implement more stringent restrictions after travel. They may also choose to incorporate questions about recent travel into their daily health screenings.

## NON-MEDICAL (CLOTH) FACE COVERINGS [UPDATED]

(For more information, see *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section F. Non-Medical (Cloth) Face Coverings*)

### 1. Who should and should not wear non-medical (cloth) face coverings? [UPDATED]

Under Mayor Bowser’s Order 2020-080 on masks issued on July 22, 2020, individuals in Washington, DC must wear a mask when they leave their homes. The full Mayor’s Order on masks can be found [here](#).

DC Health created a demonstration on how to use a mask safely, which can be found [here](#). Further guidance from CDC on the use of face coverings, including instructions on how to make and safely remove a cloth covering, is available [here](#).

| Group*                   | Should they wear a face-covering**?                | Additional Information  |
|--------------------------|--|---|
| Children younger than 2  | No   | N/A   |
| Children age 2 and older | Yes, when feasible and developmentally appropriate | <p>Face coverings must be worn. Parents and child care staff should discuss individual considerations for children of any age, including medical or developmental conditions that may prevent them from wearing a mask, and consult with the child’s healthcare provider if necessary (e.g., for children with certain conditions such as asthma), to determine if an individual child is able to wear a mask and attend childcare safely. Children must be able to safely use, avoid touching, and remove the covering without assistance.</p> <p>Staff may assist children in putting on their masks as long as proper hand hygiene is followed and staff are careful not to touch the child’s eyes, nose or mouth as feasible.</p> <p>Face coverings should <i>not</i> be worn by children during naptime.</p> |
| Parents/Guardians        | Yes  | Must wear non-medical face coverings any time they interact with child care staff, including for drop-off and pick-up.  |

|  |     |   |
|--|-----|---|
| <b>Child care staff and essential visitors</b> | Yes | Must wear at all times when in the facility. (See question 2 below for exceptions). |
|--|-----|---|

\*Non-medical (cloth) face coverings should *not* be placed on children younger than age 2, anyone who has trouble breathing (e.g., asthma), or anyone who is unconscious or unable to remove the mask without assistance.

\*\*If children play with their or others' face coverings *or* if the face-covering cannot be removed and stored safely, their use should be discontinued.

**2. Must non-medical (cloth) face coverings be worn at all times and in all places of a child development facility? Are there instances when a face covering can be removed?**

Face coverings must be worn by staff and essential visitors at all times and in all places of a facility, except in the very limited circumstances articulated below. Face coverings minimize the spread of respiratory droplets through the air. Wearing a face covering at all times and in all places reduces the risks of an asymptomatic person spreading secretions to surfaces, especially high-touch surfaces, and transmitting the virus to another individual who comes in contact with that surface. **Essential visitors** to child care should be strictly limited. Any essential visitor must wear a face covering at all times on the facility grounds and inside the facility buildings.

There are very limited exceptions in which face coverings do not need to be worn:

- Non-medical face coverings **should not** be placed on children younger than age 2, anyone who has trouble breathing, or anyone who is unconscious or unable to remove the mask without assistance.
- Face coverings **should not** be worn by children during naptime.
- When participating in vigorous physical activity outdoors, face coverings do not need to be worn if social distancing of at least six feet is feasible. When outdoors but *not* participating in physical activity, face coverings must continue to be worn.
- Face coverings do not need to be worn by anyone who is actively drinking or eating a meal.
- Face coverings do not need to be worn when in an enclosed office that no one else is permitted to enter.
- Staff may wear face coverings with clear plastic windows, or briefly remove their face coverings, when interacting with children with disabilities identified as having hearing or vision impairments, who require clear speech or lip-reading to access instruction.

**3. How can child care facilities ensure the safe use of clean face coverings? [UPDATED]**

Ensure additional protocols are in place to support the safe use of clean face coverings:

- Staff and children wearing face coverings should bring multiple clean coverings each day, as feasible.
- Child care facilities are encouraged to have face coverings available to staff, children, and essential visitors in the event they forget or soil their face coverings.
- Staff and children must exercise caution when removing the face covering, always store it out of reach of other children, and wash hands immediately after removing. Be careful not to touch eyes, nose or mouth while removing the covering.

- Face coverings that are taken off temporarily to engage in any of the activities (listed in question 2 above) should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage.
- The folded face covering can be stored between uses in a clean sealable paper or plastic bag or breathable container. They can also be placed next to the child on a napkin or directly on the table, if the surface is cleaned afterward.
- When not being worn, face coverings should be stored in a space designated for each child that is separate from others. Children's face coverings should also be clearly identified with their names or initials, to avoid confusion or swapping. Children's face coverings may also be labeled to indicate top/bottom and front/back.
- As much as possible, staff should prevent children from playing with their or others' face coverings and should ensure they are removed and stored safely.
- Children and staff should be taught to speak more loudly, rather than remove their face covering, if speaking in a noisy environment.

Note: Face coverings or masks with exhalation valves or vents must NOT be worn in child care facilities. This type of mask does not prevent the person wearing the mask from transmitting COVID-19 to others (source control).

The following resources will help ensure face coverings are used properly and safely:

- [CDC Video on How to Properly Put on PPE](#)
- [CDC How to Properly Wear a Cloth Face Covering](#)
- [DC Health Video on How to Properly Wear a Face Covering](#)
- [CDC on How to Properly Wash Hands](#)

**4. Is a hat or headband with a plastic shield that covers the face sufficient for a face covering or mask? What about when children need to see caregivers' facial expressions? [UPDATED]**

Based on the CDC [guidance](#), face shields are **not** a sufficient replacement for a cloth face covering or face masks for those individuals for which wearing a face covering may be difficult. Face shields may be used **in addition** to face coverings or masks in specific circumstances. See Appendix B of the guidance for more information on PPE.

Staff may wear face coverings with clear plastic windows, or briefly remove their face coverings, when interacting with children with disabilities identified as having hearing or vision impairments, who require clear speech or lip-reading to access instruction.

**5. How can I support young children to feel more comfortable with wearing a face covering?**

It's understandable that children may be afraid of cloth face coverings at first. Practicing with young children can be very effective at supporting the safe and routine use of face coverings.

The American Academy of Pediatrics offers additional guidance on cloth face coverings for children during COVID-19, including age-specific tips for supporting children to feel more comfortable with masks. This guidance can be found [here](#).

**6. How should non-medical reusable cloth face coverings be washed? [NEW]**

Cloth face coverings should be washed regularly, ideally after every use. If washing by machine, throw your face covering in with your regular laundry, use regular laundry detergent and the warmest appropriate water setting for the cloth used to make the mask. If washing by hand, soak the face covering in the bleach solution (4 teaspoons of 5.25%– 8.25% bleach per quart of room temperature water) for five minutes. Some bleach products, such as those designed for safe use on colored clothing, may not be suitable for disinfection. Check the label to see if your bleach is intended for disinfection. After soaking, discard the bleach solution down the drain and rinse the face covering thoroughly with cool or room temperature water.

Whether washing by hand or machine, make sure to completely dry the face covering after washing. If using the dryer, use the highest heat setting and leave in the dryer until completely dry. If air drying, lay the face covering flat and allow to completely dry. If possible, place the mask in direct sunlight when air drying.

The CDC has a great resource on safe practices for washing cloth face coverings found [here](#).

**7. What constitutes an appropriate non-medical (cloth) face covering? [NEW]**

Non-medical face coverings are made of cloth and are what CDC and DC Health call for use by private citizens, as well as child care staff and children. They are distinct from medical face coverings, like surgical masks and N95 respirators, which are used by frontline responders and health care workers and are categorized as medical devices.

Non-medical (cloth) face coverings should be made of at least two or three layers of washable, breathable fabric. The face covering should fully cover your nose and mouth, and fit snugly against the sides of your face and chin with no gaps.

A loose bandana or handkerchief tied across the face is not adequate in the child care setting because it does not fit snugly against the sides of the face and under the chin. Neck “gaiters” may be used as face coverings, as long as they fully cover the nose and mouth and are at least two layers thick (folded over the create at least two layers).

Surgical masks should only be worn by child care facility staff under certain circumstances where enhanced PPE is necessary. See Appendix B of the Health and Safety Guidance for Child Care Providers for more information.

## **HYGIENE [UPDATED]**

*(For more information, see Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section G. Hygiene)*

**1. Caring for young children, especially infants and toddlers, can require close contact to ensure appropriate care. What additional steps can child care providers take to protect themselves when caring for very young children?**

It is important to comfort crying, sad, and/or anxious infants and toddlers, and they often need to be held. When washing, feeding or holding very young children, child care providers must:

- Protect themselves by wearing a gown/coverall (such as an over-large button-down, long-sleeved shirt), non-medical (cloth) face coverings, and by wearing long hair up off the collar in a pony-tail or other updo.
- Wash their hands, arms or body and anywhere touched by a child's secretion or any soiled clothing or material.
- Change the child's clothes or their own clothes if touched by any secretions.
  - Contaminated clothes should be placed in a plastic bag or washed in a washing machine.
  - Infants, toddlers, and their providers should have multiple changes of clothes on hand in the child care center or home-based child care.
- Child care providers must wash their hands before and after handling infant bottles prepared at home or prepared in the facility. Bottles, bottle caps, nipples, and other equipment used for bottle-feeding must be thoroughly cleaned after each use by washing in a dishwasher or by washing with a bottle brush, soap, and water.

CDC provides further guidance on safe diaper changing procedures that can be found [here](#).

Additional PPE requirements for educators and staff in close contact with children, and/or working with any individual with suspected or confirmed COVID-19, are articulated in Appendix B of the *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period*.

**2. Is hand sanitizer an effective substitute for hand washing during the school day when soap and water are not available? [NEW]**

If soap and water are not available and hands are not visibly dirty, staff and children may use an alcohol-based hand sanitizer that contains at least 60 percent alcohol. It is **critical** that young children be closely monitored if using hand sanitizer, as ingestion can be harmful.

## CLEANING, DISINFECTION, AND SANITIZATION [UPDATED]

*(For more information, see Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section H. Cleaning, Disinfection, and Sanitization)*

**1. What is a schedule for 'regular' and 'frequent' cleaning, sanitizing, and disinfecting of high-touch surfaces, toys, games, bedding, etc.? [UPDATED]**

Child care providers must routinely clean and disinfect surfaces and objects that are frequently touched; at a minimum, high-touch surfaces must be cleaned and disinfected daily, and as often as possible. This may include cleaning objects/surfaces not ordinarily cleaned daily (e.g., doorknobs, light switches, classroom sink handles, countertops). For an example schedule for routine cleaning, sanitizing, and disinfecting child care facilities and guidance for selecting cleaning products, please refer to [OSSE's Supplementary Guidance for Cleaning, Sanitizing, and Disinfecting Child Care Facilities](#).

Use all cleaning, disinfecting, and sanitizing products according to the manufacturer's instructions for concentration, application method, contact time, and drying time before use by a child. Use [EPA-approved disinfectants effective against SARS-CoV2 \(COVID-19\)](#). When feasible, preference



should be given to products with asthma-safer ingredients (e.g., citric acid or lactic acid). See question 4 below for more information on selecting products.

When cleaning, disinfecting and sanitizing surfaces during routine cleaning, staff should wear gloves and a face covering to protect themselves from any potential contamination. Custodial, as well as other staff who may be performing deeper cleaning and disinfecting throughout the building, must adhere to PPE requirements as articulated in Appendix B in the *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period*.

**2. If a child, staff member, or essential visitor develops symptoms of COVID-19 throughout the day, but has not had a confirmatory COVID-19 test, do I need to take additional steps to clean, disinfect, and sanitize?**

Immediately rope off or close, then clean and disinfect areas and equipment in which the ill individual has been in contact. Once the room is vacated at the end of the day, perform deep cleaning and disinfection of full classroom, and any other spaces or equipment in which the ill individual was in contact. *This includes the isolation room after use by an ill child or staff member.* Staff supporting, accompanying or cleaning up after a sick child must adhere to PPE requirements as articulated in Appendix B.

**3. If a child, staff member, or essential visitor is confirmed to have COVID-19, are there extra steps to clean, disinfect, and sanitize properly? [UPDATED]**

If seven days or fewer have passed since the individual who is sick used the facility, follow these steps:

- Close off areas used by the individual who is sick.
  - Note: Such areas must be immediately roped off or closed if it is during the day when the COVID-19 case is confirmed AND the COVID-19 positive individual is in the building. If it is during the day when the COVID-19 case is confirmed AND the COVID-19 positive individual was appropriately excluded from in-person activities while awaiting test results, it is acceptable to close, clean, and disinfect the spaces used by the COVID-19 positive individual after the children and staff in those spaces leave for the day.
- Open outside doors and windows to increase air circulation in the areas.
- Wait 24 hours or as long as possible before cleaning or disinfecting to allow respiratory droplets to settle.
- Clean and disinfect all areas used by the individual who is sick, such as classrooms, bathrooms, and common areas.

If more than seven days have passed since the individual who is sick used the facility, additional cleaning and disinfection is not necessary. Continue routine cleaning and disinfection. Staff conducting cleaning must adhere to PPE requirements as articulated in Appendix B.

**4. What is the best way to select cleaning, disinfecting and sanitizing products and determine how to use them safely? [NEW]**

- Use [EPA-approved disinfectants effective against SARS-CoV2 \(COVID-19\)](#). When feasible, preference should be given to products with asthma-safer ingredients (e.g., citric acid or lactic acid).

- For all cleaning, disinfecting, and sanitizing products, follow the manufacturer's instructions for concentration, application method, contact time, and drying time before use by a child. Ensure safe storage of all cleaning products. See [OSSE's Supplementary Guidance for Cleaning, Sanitizing, and Disinfecting Child Care Facilities](#) and [CDC's guidance for safe and correct application of disinfectants](#). Dirty surfaces must be cleaned with a detergent or soap and water before disinfection.
- Custodial staff, as well as classroom educators and other staff who may be cleaning and disinfecting spaces throughout the building, must adhere to PPE requirements as articulated in Appendix B.

## HIGH-RISK INDIVIDUALS [UPDATED]

*(For more information, see Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section I. High Risk Individuals)*

### 1. Are there any individuals who should NOT participate in congregate child care during the COVID-19 public health emergency? [UPDATED]

Child care providers must notify all families and staff that DC Health recommends that any individual at high-risk for experiencing severe illness due to COVID-19 consult with their medical provider **before** participating in child care activities.

- People with the following conditions **are at increased risk** of severe illness from COVID-19:
  - Cancer
  - Chronic kidney disease
  - COPD (Chronic obstructive pulmonary disease)
  - Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
  - Immunocompromised conditions
  - Obesity (Body Mass Index (BMI) of 30 kg/m<sup>2</sup> or higher but less than 40 kg/m<sup>2</sup>)
  - Severe obesity (BMI greater than or equal to 40 kg/m<sup>2</sup>)
  - Pregnancy
  - Sickle cell disease
  - Smoking
  - Type 2 diabetes mellitus

A complete list of conditions that might place an individual at increased risk for severe illness from COVID-19 is available [here](#).

Any staff member or parent/guardian of a child who has a medical condition not listed, but who is concerned about their safety, should also consult with their healthcare provider before participating in child care activities.

Child care providers are not required to secure written clearance from high-risk individuals prior to participating in congregate child care.

## MEALS [UPDATED]

*(For more information, see Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section J. Meals)*

### 1. How can we ensure safe practices if children bring their own lunch?

The lunch should either be placed in the child's cubby or, if needing to be refrigerated, a staff member wearing gloves should wipe the outside down prior to storing in the fridge. When handling individual lunch boxes at meal time, staff must wash their hands between the handling of each lunch box. Food items should be removed from the lunch box and placed with the child, or plated separately, and then the lunch box should be returned to the child's cubby. Note: Children may open and handle their own lunch boxes if developmentally appropriate.

Schools must ensure that students are not exposed to foods to which they have known allergens.

### 2. How does our facility navigate hygiene during meals? [NEW]

Children must wash hands before and after eating and may not share utensils, cups, or plates. Staff must wash hands before and after preparing food and after helping children to eat. Tables and chairs must be cleaned and sanitized before and after the meal, and staff must routinely clean, disinfect and sanitize surfaces and objects that are frequently touched such as kitchen countertops, tables, door handles, and carts. Staff must follow all PPE requirements in Appendix B and as required per food safety regulations or requirements, including wearing gloves whenever handling food products and change gloves and washing hands when changing activities.

### 3. We serve meals family-style. How do we adjust meal service to meet the health and safety guidelines? [NEW]

Meals must be served individually, in alignment with safe practices outlined in questions #1 and 2 above. If meals are typically served family-style or from a hot bar or salad bar, plate each child's meal to serve it so that utensils are not shared.

## EXCLUSION, DISMISSAL, AND RETURN TO CARE CRITERIA AND PROTOCOLS [UPDATED]

*(For more information, see Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section K. Exclusion, Dismissal, and Return to Care Criteria and Protocols)*

### 1. OSSE's guidance references excluding children or staff who have had close contact with someone confirmed COVID-19 positive. How should we define "close contact"? [UPDATED]

DC Health's contact tracers conduct an investigation for any positive case of COVID-19, and will identify those who meet criteria for "close contact" with the positive individual. A number of factors are taken into account by contact tracers when defining close contact and appropriate next steps, including whether individuals were wearing face coverings, and the type and length of exposure.

DC Health will contact anyone deemed to be a close contact of a person identified as a positive case of COVID-19, and child care providers **do not** need to independently make that decision. For

awareness, “close contact” is defined as having been within 6 feet of a COVID-19-positive individual for a total of 15 or more minutes in a 24-hour period during the individual’s infectious period. These 15 or more minutes may be non-consecutive.

## **2. What should I do if a child or staff member becomes ill during the day?**

If at any point throughout the day, a child, staff member or essential visitor develops a fever or other signs of illness, the program director must follow the dismissal criteria detailed *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section K. Exclusion, Dismissal, and Return to Care Criteria and Protocols*, and OSSE Licensing Guidelines regarding the exclusion and dismissal of children, staff members, and essential visitors.

- For children, the program director must immediately isolate the child from other children. If developmentally appropriate, the child should put on a cloth (non-medical) or surgical face covering, if not wearing already.
  - Notify the child’s parent/guardian of the symptoms and that the child needs to be picked up *as soon as possible*, and instruct them to seek health care provider guidance.
  - Identify a staff member to accompany the isolated child to the isolation area and supervise the isolated child while awaiting pickup from the parent/guardian.
    - The staff member(s) briefly responding to the sick child in the classroom, accompanying the child to the isolation area, and supervising the child in the isolation area must comply with PPE requirements per Appendix B.
  - Follow guidance for use of the isolation room below.
  - Immediately follow all cleaning and disinfection protocols for any area and materials with which the child was in contact, per Section H: Cleaning, Disinfection, and Sanitization.
- For staff and essential visitors, the program director must send the staff member or essential visitor home immediately or isolate until it is safe to go home, instruct the staff member to seek healthcare provider guidance, and follow cleaning and disinfecting procedures for any area, toys, and equipment with which the staff member or essential visitor was in contact.

*Isolation Room:* Providers must identify a well-ventilated space to isolate sick individuals until they are able to leave the facility. The space should be in an area that is not frequently passed or used by other children or staff, and not simply behind a barrier in a room being utilized by other individuals. If safe and weather permitting, providers are encouraged to isolate sick individuals outdoors under appropriate supervision. When in the isolation area, the sick individual must wear a non-medical (cloth) face covering or surgical mask (if developmentally feasible), be within sight of the supervising staff member, and be physically separated from other individuals by at least six feet. Isolate only one sick individual in the isolation area at a time. The isolation area must be immediately cleaned and disinfected after the sick individual departs. Supervising staff must comply with the PPE requirements in Appendix B.

## **3. If a child or staff member is excluded or absent due to COVID-19 or exposure to someone with COVID-19, when can they come back to child care? [NEW]**

Table 1 from the *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section K. Exclusion, Dismissal, and Return to Care Criteria* identifies the criteria that child care providers must use to allow the return of a child or staff member with:

- (1) COVID-19 symptoms;

- (2) Positive COVID-19 test results (Antigen or PCR Test);
- (3) Negative COVID-19 test results after symptoms of COVID-19;
- (4) Documentation from a healthcare provider of alternate diagnosis after symptoms of COVID-19;
- (5) Close contact of an individual with confirmed COVID-19;
- (6) Close contact of an individual awaiting a COVID-19 test result; or
- (7) Travel to any place other than Maryland, Virginia, or a Low-Risk State, Country or Territory.

Child care providers may also reference the OSSE Return to Care Criteria graphic found [here](#).

**4. Does a child care facility need to have more than one isolation area? [NEW]**

Yes. Child care facilities must isolate only one sick individual in the isolation area at a time. Thus, providers should identify multiple rooms that may be used as isolation areas in the event more than one individual becomes sick at the same time.

## EXPOSURE REPORTING, NOTIFICATIONS, & DISINFECTION [UPDATED]

*(For more information, see Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period, Section L. Exposure Reporting, Notifications & Disinfection)*

**1. Should each child care provider identify a COVID-19 point of contact?**

To ensure a clear and efficient process for communication each child care provider should identify a staff member as the COVID-19 point of contact (POC). This person is responsible for:

- Ensuring the below steps are followed in the event of a confirmed case of COVID-19.
- Ensuring that the child care facility has contact information for all contract staff. It is critical DC Health has reliable contact information in the event of a positive case or close contact among contract staff.
- Acting as the POC for families and staff to notify if a child or staff member test positive for COVID-19.

**2. If a child or staff member is confirmed to have COVID-19, how does the child care provider report this information to OSSE and DC Health? [UPDATED]**

The facility must follow existing procedures for reporting communicable disease. Facilities must notify DC Health when:

- A staff member or essential visitor who has been on the facility grounds notifies the facility they tested positive for COVID-19 (not before results come back);

OR

- A parent/guardian notifies the child care facility that a child tested positive for COVID-19 (not before results come back)

AND

- The individual was on the grounds of the facility or participated in facility activities **during their infectious period** (two days before symptom onset or date of test if asymptomatic, and typically ending 10 days after symptom onset/test date).

In the event of a confirmed case of COVID-19 in a child, staff member, or essential visitor, child care providers must complete the following steps as soon as possible on the same day the case was reported to the facility:

- File an Unusual Incident Report (UIR) with OSSE by sending it to [OSSE.ChildCareComplaints@dc.gov](mailto:OSSE.ChildCareComplaints@dc.gov) **and**
- Notify DC Health by submitting an online form on the DC Health COVID-19 Reporting Requirements website [dchealth.dc.gov/page/covid-19-reporting-requirements](https://dchealth.dc.gov/page/covid-19-reporting-requirements)
  - Submit a **Non-Healthcare Facility COVID-19 Consult Form**

Child care providers should refer to DC Health's [First Steps for Non-Healthcare Employers when Employees Test Positive for COVID-19](#) when determining steps for reporting positive cases to DC Health.

In the event of a confirmed COVID-19 case, child care providers do not need to automatically close. DC Health will instruct child care providers within 24 hours on dismissals and other safety precautions in the event a known COVID-19 positive individual came in close contact with others at the facility. Please note this response time may increase if cases of COVID-19 increase in the District.

If a child care provider is seeking COVID-19 advice other than related to a confirmed case, as above, they may contact [OSSE.DELcommunications@dc.gov](mailto:OSSE.DELcommunications@dc.gov).

### **3. How does the child care center communicate information about a positive COVID-19 case to families and staff? [UPDATED]**

Child care providers must have communication protocols in place that protect the privacy of individuals and alert their families and staff to a COVID-19 case. DC Health will identify close contacts based on its case investigation. It is not the responsibility of the provider to define those who must quarantine. Communication is to be completed per DC Health directive and will include:

- Notification to the entire program or the affected classroom that there was a COVID-19 positive case, those impacted will be notified and told to quarantine, steps that will be taken (e.g., cleaning and disinfection), and the facility's operating status;
- Education about COVID-19, including the signs and symptoms of COVID-19, available at [coronavirus.dc.gov](https://coronavirus.dc.gov);
- Referral to the Guidance for Contacts of a Person Confirmed to have COVID-19, available at [coronavirus.dc.gov](https://coronavirus.dc.gov);
- Information on options for COVID-19 testing in the District of Columbia is available at [coronavirus.dc.gov/testing](https://coronavirus.dc.gov/testing); and
- Information for staff on accessing priority testing at the public testing sites, including the location of public testing sites, available at [coronavirus.dc.gov/testing](https://coronavirus.dc.gov/testing). Child care staff may identify to the testing site staff that they are educators or child care staff to receive priority. Priority does not affect the turnaround time for receiving test results.

## GENERAL QUESTIONS

### **1. What steps should child care providers take upon opening and closing each day?**

OSSE developed a Health and Safety Checklist for Child Care that can be used to support child care providers in implementing OSSE's *Health and Safety Guidance for Child Care Providers: COVID-19 Recovery Period*. This document, which can be accessed [here](#), includes two checklists as follows:

- Be Prepared Every Day: A Daily Health and Safety Checklist. This checklist can be used every day by child care providers to support the facility's readiness to receive children and staff members.
- Policy and Process Preparedness Health & Safety Checklist. This checklist can be used to help providers ensure they have the right policies and processes in place to protect the health and safety of their staff and families during this public health emergency.

### **2. Will OSSE and DC Health be able to forecast when there will be a change in health and safety guidance that impacts child care operations?**

CDC and DC Health will continue to evaluate the health conditions and provide updates on the necessary policies and processes for protecting health and safety. If the public health data allows or requires updates to be made to the health and safety guidance, OSSE will work with DC Health to update our guidance and communicate accordingly to providers.

**For resources and information about the District of Columbia Government's coronavirus (COVID-19) response and recovery efforts, please visit [coronavirus.dc.gov](https://coronavirus.dc.gov).**