DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

Health and Safety Guidance for Schools: Coronavirus (COVID-19) Recovery Period

(Updated June 25, 2021)

The Office of the State Superintendent of Education (OSSE) issues this guidance to District of Columbia public, public charter, private, parochial, and independent elementary and secondary schools, as well as adult education schools, that are operating during the recovery period from the coronavirus (COVID-19) public health emergency. This document is based on guidance from the Centers for Disease Control and Prevention (CDC) and the District of Columbia Department of Health (DC Health).

This guidance is effective as of June 25, 2021 and supersedes any previously released guidance by OSSE on the topic. This document incorporates reopening guidance for schools issued by DC Health on May 19, 2021 and provides additional guidance on select topics.[1]

Where activities for schools are noted with "**must**," the activities are mandatory. Provisions noted with "**should**" or "**as feasible**" are not required but are **recommended** to reduce the risk of COVID-19, as appropriate within a given school setting. This guidance may be superseded by any applicable Mayor's order, regulation, or health mandate from DC Health.

As articulated in Mayor's Order 2021-69, LEAs should operationalize education guidance as it relates to COVID-19 to the extent feasible to ensure full access to in-person learning.

Per DC Health guidance and unless otherwise stated in this guidance, individuals who have been vaccinated against COVID-19 should continue following all precautions in schools until DC Health instructs otherwise, including wearing face masks, physical (social) distancing, practicing hand hygiene, and frequently cleaning commonly touched surfaces and items.

For more information on the District of Columbia Government's response to coronavirus (COVID-19), please visit coronavirus.dc.gov. The CDC's most recent, supplemental guidance for schools can be accessed here. This guidance will be updated as additional recommendations from the CDC or DC Health become available.

[1] Pursuant to various Mayor's Orders, DC Health guidance must be followed. See, e.g., Mayor's Order 2020-075, *Phase Two of Washington, DC Reopening*, Section II.3 (June 19, 2020), Mayor's Order 2020-079, *Extensions of Public Health Emergency and Delegations of Authority During COVID-19*, Section V.3 (July 22, 2020), Mayor's Order 2021-060, *Modified Measures in Phase Two of Washington, DC Reopening* Section XII.1 (April 26, 2021), Mayor's Order 2021-066, *Wearing of Masks and Other Activities in the District of Columbia to Prevent the Spread of COVID-19 Including Modification for Fully-Vaccinated Persons* Section IX.1 (May 1, 2021), Mayor's Order 2021-069: *Modified Measures for Spring/Summer 2021 of Washington, DC Reopening and Extension of Public and Public Health Emergencies* (May 17, 2021).

The information in this guidance is divided into four sections. The first section on prevention addresses the actions that schools either must or should take to protect the school community and slow the spread of COVID-19. The second section on response addresses the actions that schools either must or should take when an individual becomes sick with or exposed to COVID-19. The third section provides information on reopening plans that LEAs and private, parochial, and independent schools are required to submit to OSSE. Finally, the appendices provide additional information on physical temperature checks, personal protective equipment (PPE), and COVID-19 testing.

A layered mitigation strategy is the most effective approach to preventing the spread of COVID-19 in schools. The risk of in-person learning can be lowered depending on the mitigation strategies put in place and the extent to which they are followed. This guidance provides strategies to minimize risk while allowing for in-person learning. Schools should be prepared to increase or decrease mitigation strategies based on the case rate in the community and spread or outbreaks occurring within individual schools. Deviation from these guidelines increases the risk of COVID-19 exposure and in-school community transmission. Given the benefits of in-person learning, schools should make adjustments to their implementation of these recommendations when strict adherence would prevent all students from returning to the school building.

Schools should institute an auditing program at least every two weeks to monitor the implementation of practices described in this guidance document.

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PREVENTION

A. COMMUNICATION WITH STUDENTS, STAFF AND FAMILIES

To support clear communication with students, staff, and families, schools should 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 face mask).

To support clear communication with students, staff, and families, schools should:

- Include messages about behaviors that prevent the spread of COVID-19 when communicating with staff and families (such as on school websites, in emails, and on school social media accounts).
- Educate staff, students, and families about COVID-19, physical (social) distancing, when they must stay home, and when they can return to school.
- Educate staff on COVID-19 prevention and response protocols.
- Broadcast regular announcements on reducing the spread of COVID-19 on PA systems and/or daily bulletins.

To ensure a clear and efficient process for communication each school must identify a staff member as the COVID-19 point of contact (POC). This person would act as the POC for families and staff to notify if a student or staff member tests positive for COVID-19; ensure that the LEA/school has contact information for all contract staff, in the event one is confirmed to have or is exposed to COVID-19; and would be responsible for ensuring the appropriate steps are followed in the event of a confirmed case (see Section N: Exposure Reporting, Notifications and Disinfection).

B. VACCINES AND HEALTH FORMS

Routine Pediatric Vaccinations

According to the Centers for Disease Control and Prevention (CDC) and DC Health data, the COVID-19 pandemic has resulted in a significant reduction in childhood immunization administrations across the country including in the District of Columbia and Maryland.

To prevent a vaccine-preventable disease outbreak in a school setting, all students must be **fully vaccinated** according to CDC and DC Health standards.[2]

[2] DC Official Code § 38–501 et seq. and DCMR 5-E § 5300 et seq.

- Implement the Immunization Policy for In-Person Attendance in full.
- Ensure a procedure is in place for frequently reviewing immunization compliance, identifying and notifying non-compliant families, and removing non-compliant students from in-person instruction after the 20-school day period.
- A list of pediatric immunization locations can be found here. A search tool to find a primary care center in DC can be found here.
- A review of immunization requirements and health forms can be found here.

COVID-19 Vaccination

- Teachers, school staff, and students should be vaccinated as soon as clinical recommendations allow.
    - For more information on getting the COVID-19 vaccine, visit coronavirus.dc.gov/vaccine.
- Access to COVID-19 vaccination should not be considered a prerequisite to reopening schools for in-person instruction.

Health Forms

Generally, students in the District must provide their school a certificate of health and evidence of an oral health examination on an annual basis.[3] For the 2020-21 school year, students who have a health form on file from the prior school year (i.e., those who are re-enrolling at the same school as the 2019-20 school year *and* those who were enrolled in any District public or public charter school that participated in the School Health Services Program in the 2019-20 school year) were granted an extension to submit their Universal Health Certificate (UHC) and Medication and Treatment Authorization Forms by Nov. 2, 2020, to meet this annual requirement. Oral Health Assessments (OHAs) must have been submitted by Jan. 31, 2021. All students must now be caught up on necessary health forms and immunizations as required by District law.

Both the old and new versions of the health forms shall be accepted. Partial UHCs completed via telehealth visits shall be accepted. Submission of completed UHCs and OHAs is not a prerequisite for attendance; as such, students should not be excluded from in-person activities for failure to submit the UHC or OHA.[4]

C. REOPENING AND MAINTAINING BUILDINGS

Schools that are reopening after a prolonged facility shutdown should perform necessary maintenance to all ventilation and water systems and features (e.g., sink faucets, drinking fountains, decorative fountains) so that they are ready for use and occupancy and are adequately maintained throughout the operating period.

Schools should verify ventilation systems operate properly, including inspecting and routinely replacing HVAC filters and checking that all HVAC system components and exhaust fans, if applicable, are operable to design.

Schools should increase the circulation of outdoor air as much as possible; for example, by opening windows and doors. Increase in air circulation should be continued after reopening where safe and

[3] DC Official Code § 38–601 et seq.
[4] DC Official Code § 38–604(a).

possible. Fans may be used to increase the effectiveness of open windows. Schools should not open windows and doors if doing so poses a safety or health risk (e.g., risk of falling, triggering asthma symptoms) to students and staff using the facility. Under **no circumstances** may fire-rated doors be propped or otherwise left open.

Schools should consider ventilation system upgrades or improvements and other steps to increase the delivery of outside filtered air to aid in the dilution of potential contaminants in the school. In consultation with an experienced HVAC professional, schools 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**.**

Schools should flush water systems to clear out stagnant water and replace it with fresh water. This will remove any metals (e.g., lead and copper) that may have leached into the water and minimize the risk of Legionnaires' disease and other diseases associated with water. Steps for this process can be found on the CDC website.

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.

D. PHYSICAL (SOCIAL) DISTANCING

Recent data released by CDC has indicated that to allow more students back into school, there are times when 3 feet of physical distancing can be implemented. School leaders should review the guidelines below carefully so that they are operationalized in the best way to support teacher and student safety, while allowing increased access to in-person schooling. As certain preventive measures are being relaxed, it is critical to remember the importance of layered mitigation strategies to prevent the spread of COVID-19 between teachers, staff, and students to help keep schools open, even when a case occurs in a school.

Schools should implement appropriate physical distancing by maintaining the following physical distancing, to the maximum extent feasible, in both indoor and outdoor settings.

- **Three feet of physical distancing** is recommended for the following groups:
    - Between students in elementary school **while in classrooms**.
    - Between students **in classrooms** in middle and high schools. If DC is experiencing a daily case OR positivity rate indicating substantial community spread, 3 feet of physical distancing should not be implemented without cohorting in this age group.
    - Daily case and positivity rates of COVID-19 in DC can be found at coronavirus.dc.gov/page/reopening-metrics. A metric in substantial community spread is indicated as being red on the chart.
- **Six feet of physical distancing** is recommended for the following scenarios:
    - Between adults (teachers, staff, and essential visitors) at all times during school and school-related activities.
    - Between students (including those above age 18) and adults (teachers, staff and essential visitors) at all times during school and school-related activities.
    - In middle and high schools when DC is experiencing a daily case OR positivity rate

indicating substantial community spread (red), and cohorting is not able to be implemented.
    - During activities when face masks cannot be worn, such as eating. If schools allow students to eat in classrooms, strategies should be implemented to allow increased spacing between students during meal and snack times. Physical barriers do not replace physical distancing.
    - During physical education class and while participating in athletics.
    - Between cohorts.
    - In any school common areas outside the classroom.

Maintaining Cohorts

Cohorting consists of dividing students and teachers into distinct groups that stay together throughout the entire school day. As physical distancing recommendations have decreased, cohorting is an important part of maintaining school operations if and when a case occurs in a school. Minimizing mixing between cohorts will decrease the number of students and staff that are potentially exposed if a case occurs in a teacher, staff member, or student.

- Cohorting of students is recommended to the greatest extent possible to minimize exposure across the school environment.
- Physical distancing recommendations should be followed within cohorts.
- Cohorts should have minimal to no interaction with other cohorts and remain distinct to the greatest extent possible, as mixing cohorts poses an avoidable risk of exposure if an individual tests positive for COVID-19.
- Schools should take special steps to prevent mixing between cohorts at these times: during entry and exit of the building, at mealtimes, in the restroom, on the playground, in the hallway, and in other shared spaces.
- Cohorts should be maintained for all activities including lunch and recess.
- Please note: If there are daily case OR positivity rates indicating substantial levels of community spread in DC and cohorting is not possible for middle and high school students, 6 feet of physical distancing between students is strongly recommended by DC Health.

Traveling to and from School

- Students and staff should be encouraged to maintain physical distance, to wear a face mask when traveling, and to avoid congregating in large groups at intersections and transit stops.
- If transport vehicles (e.g., buses) are used by the school, drivers must wear face masks and should practice all safety actions and protocols as indicated for other staff (e.g., hand hygiene).
- To the extent feasible, schools should promote physical distancing and improved ventilation on school buses and shared transport (e.g., leaving empty rows of seats, opening windows).

Entering and Exiting School

Strategies to support physical (social) distance when entering/exiting school may include:

- Staggering arrival and/or dismissal times.
- Opening additional doors for entry and exit to avoid funneling all students through a single point of entry.
    - Direct students to the door closest to their classroom or homeroom when necessary to avoid congestion and crowding. In instances where the closest door to the classroom or

homeroom is inaccessible for students with disabilities, schools should consider individualized planning for entry and exit from the school building.

- Creating clear space delineations for student lines as students enter and exit school, as well as inside the school building (e.g., create and mark line spots in hallways and outdoors, mark one-way flow of hallways).

During the School Day

Grouping

- *Students:*
  - Schools should implement small groups for activities and support students with maintaining the recommended physical distance.
  - When creating cohorts, schools should not group students by perceived ability or in ways that perpetuate tracking.
  - When necessary to provide push-in or pull-out services for an individual or small group of students with disabilities individuals from groups may mix, but they must follow face mask provisions and should follow physical (social) distance recommendations to the extent feasible.
  - If necessary, it is acceptable for in-person groups in before- and after-care programs to be distinct from those during the school day. However, to the greatest extent possible, students participating in before- and after-care programs should remain in a stable group, without mixing with other groups, each day that they participate in the program and should adhere to all physical (social) distancing and other provisions in this guidance.
  - When grouping students, LEAs should make determinations in consideration of students' individualized education programs (IEPs) and least restrictive environment (LRE). LEAs should consider the IEPs and 504 Plans of each student to determine how the LEA will implement the accommodations and modifications required in the IEP or 504 Plan necessary to implement service delivery within the health and safety guidelines. Service considerations may be conducted using the OSSE Service Consideration Tool, modified to reflect questions related to service delivery in a hybrid service-delivery model.
  - For students with disabilities who receive related services through a group methodology, LEAs should consider alternative service delivery methodologies consistent with the service needs prescribed in the IEP or 504 Plan when designing student grouping.
- *Educators and staff:* In grades where students traditionally transition between classes, when feasible, schools are encouraged to rotate teachers and staff between classrooms, rather than students. Such rotation of teachers and staff should be limited to the extent feasible.
  - To the maximum extent feasible, limit the use of floating staff to only when necessary as the use of floating staff poses an avoidable increased risk of exposure if staff test positive for COVID-19.
  - To the maximum extent appropriate, LEAs should maintain consistency of dedicated aide and behavioral support staff when grouping students.

- To the maximum extent appropriate, LEAs should maintain a single set of related service providers designated to each student group, including for the delivery of services inside and outside of the general education setting.
- To the maximum extent feasible, transition in-person staff meetings to virtual. If staff meetings are held in-person, support adherence to physical distance and face mask provisions.

Use of Indoor Space

To support physical (social) distance in indoor spaces, schools should:

- Maximize spacing between individuals in a classroom, including while at tables and in group and individual activities.
- Remove nonessential furniture from classrooms.
- Arrange desks and furniture so that individuals are separated to maintain physical distance.
- During nap times in early education classrooms, place students head to toe, with physical distance between students head to head.
- Designate an area for students or staff who exhibit symptoms and keep separate from the area used for routine healthcare (see below Section N. Exposure Reporting, Notifications, and Disinfection).
- Schools must consider the accessibility of sinks to students with disabilities using assistive devices.
- Turn desks to face in the same direction (rather than facing each other) to reduce transmission caused from virus-containing droplets (e.g., from talking, coughing, sneezing).
- Install physical barriers, such as sneeze guards and partitions, and add reminders about physical distancing (e.g., signage, tape markings on the floor) in health offices and areas in which it may be difficult for individuals to maintain physical distance (e.g., reception areas, main office, between bathroom sinks).
- Close communal-use space such as breakrooms and lounges. If not feasible to close the space, stagger use, implement physical distance between individuals, ensure face masks are worn at all times except while eating or sleeping, and clean between uses.
- Implement a lane system in hallways, stairwells, and other common areas.
- Allow students to eat lunch and breakfast in their classrooms rather than mixing in the cafeteria. If not possible, stagger lunch by class and/or divide eating area by class, cleaning between groups, or consider outdoor options.

Use of Outdoor Space

- Schools are encouraged to use outdoor spaces for instruction, activities and meals, as feasible and as weather permits.
- Playgrounds and other outdoor spaces may be used for more than one group. To the greatest extent possible, each group of individuals should interact only with their own group and not mix between other groups. Each group should have extra physical (social) distance between them and the next group.
- When feasible, hold physical education classes outside while maintaining appropriate distance between students. Use visual cues (e.g., use chalk to indicate where a student should stand) to maintain physical distance.

Canceling, Eliminating or Modifying Activities

Schools should implement the same layered mitigation strategies used for classroom activities during physical activity in schools as well as student athletics.

- Schools should implement physical distancing of at least 6 feet between students during physical education classes, to the maximum extent feasible.
- Masks must be worn at all times while participating in physical education and sports.
- Students should be grouped into cohorts for sports practices. The cohorts should not mix, and participants within the cohorts should maintain physical distance from one another and the coaches or trainers.
- Guidance on high school sports is available from the District of Columbia State Athletic Association (DCSAA) at www.dcsaasports.org/.

To the extent feasible, schools should:

- Of note, activities in which voices are projected, such as choir or theater, or where wind instruments are used, present greater risk of spread of respiratory droplets, and should be cancelled or modified to be outdoors and/or allow for 10 feet of physical distancing.
- Consider virtual activities and events instead of field trips, student assemblies, special performances, school-wide parent meetings.
- Revise the process for receiving mail and packages. Only have necessary items delivered and combine orders so fewer deliveries are made. Routinely clean and disinfect packages.
- Minimize 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).
- Allow parents and advocates of students with disabilities seeking to observe student's receipt of services in and outside of the classroom setting. Schools may condition entrance into the school on compliance with applicable health and safety standards.

E. DAILY HEALTH SCREENING

DC Health recommends that schools perform a daily health screening for all staff and essential visitors entering the building. This includes any contractual staff (e.g., security, custodial). Screening can be performed before (via phone or app) or upon arrival. For Screening Tool Guidance, visit coronavirus.dc.gov/healthguidance. If screening is performed, it should be reviewed after submission.

Parents are strongly encouraged to monitor and screen children daily for symptoms of COVID-19. As many children with COVID-19 do not have signs and symptoms, and symptoms may be confused with other common illnesses, it is not recommended that schools consider performing an onsite daily health screen for all students entering the building. Schools should educate parents on monitoring students' health at home and should emphasize the importance of not sending children who are sick to school. Home-based screening strategies can be considered.

An individual who has symptoms of COVID-19 or who is required to isolate or quarantine due to COVID-19 diagnosis or exposure must not enter the school. Symptoms of COVID-19 include the following:

- Fever (subjective or 100.4 degrees Fahrenheit) or chills
- Cough

- Congestion or runny nose[5]
- Sore throat
- Shortness of breath or difficulty breathing
- Diarrhea
- Nausea or vomiting
- Fatigue
- Headache
- Muscle or body aches
- New loss of taste or smell

Children with COVID-19 infection often present with non-specific symptoms, such as only breathing or stomach symptoms, with the most common being cough and/or fever.

Any student, staff member, or essential visitor with any of the above symptoms must not be admitted. If they are not immediately able to leave the school premises, the student, staff member, or essential visitor should be isolated from other individuals and wear a face mask; any accompanying staff member(s) should follow PPE best practices per the "suspected or confirmed COVID-19" section of Appendix B. Such students, families, staff, or essential visitors should be instructed to call their healthcare provider to determine next steps.

Note: Students or staff with pre-existing health conditions that present with specific COVID-19 – like symptoms must not be excluded from entering the school building on the basis of those specific symptoms if a healthcare provider has provided written or verbal documentation that the specific symptoms are not due to COVID-19.

If a school chooses to implement a daily health screening for students and/or for staff and essential visitors, the screening procedure should be conducted using appropriate physical distancing and should adhere to the procedures and PPE best practices, as articulated in Appendices A and B.

A screening procedure could include the following steps (conducted using appropriate physical distancing and using face masks as outlined in this guide). Symptoms can be evaluated before arrival (e.g., via phone or app) or upon arrival and can be based on a report from caregivers. Visual inspections may take place in classrooms.

- **ASK:** Students/parents/guardians, staff, and essential visitors should be asked about whether the student, staff member, or essential visitor has experienced any of the above listed symptoms consistent with COVID-19 in the last 24 hours.

[5] 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, then the individual does not need to be excluded. The school nurse may support a determination of whether the runny nose meets criteria for exclusion, if necessary.

- **ASK:** Students/parents/guardians, staff, and essential visitors should be asked whether the student, staff member, or essential visitor has been in close contact within the past 10 days with someone confirmed to have COVID-19.[6,7]
- **LOOK:** School staff should visually inspect each student, staff member, and essential visitor for signs of illness, which could include flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness.

Per DC Health's Guidance for Travel, unvaccinated or partially vaccinated individuals who have traveled domestically to any place other than Maryland or Virginia must either (1) not attend school for 10 days after returning, or (2) not attend school until tested for COVID-19 three to five days after returning AND receive a negative COVID-19 viral test.

Per DC Health's Guidance for Travel, unvaccinated or partially vaccinated individuals who have traveled internationally must either (1) not attend school for 10 days after returning, or (2) not attend school for seven days after returning, get tested for COVID-19 three to five days after returning, AND receive a negative COVID-19 viral test. Even if the test is negative, the individual must still not attend school for seven days.

Provided that they do not currently have any symptoms consistent with COVID-19, an individual who has **tested positive for COVID-19 within the last 90 days or is fully vaccinated** may be admitted immediately after domestic or international travel.[8] They should get a COVID-19 test three to five days after international travel. Any individual with symptoms consistent with COVID-19 must not enter the school building.

For more detailed guidance related to returning from domestic and international travel, see DC Health's Guidance for Travel. Private institutions, including charter, private, parochial, and independent schools, may implement more stringent restrictions after travel. Schools may choose to incorporate questions about recent travel into their daily health screenings.

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

- Confirm that the student, staff member, or essential visitor had their temperature checked at home two hours or less before their arrival and the temperature was less than 100.4 degrees Fahrenheit.

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[6] Returning to school after 10 days is intended to minimize the risk of transmission of the virus while also minimizing the burden. DC Health guidance allows for schools to continue to implement the more stringent 14-day return to school recommendation if they choose to. Waiting 14 days before returning to school remains the most effective strategy for decreasing the transmission of COVID-19. DC Health strongly recommends that individuals who live or work with someone at higher-risk for COVID-19 (see Section I) quarantine for 14 days.

[7] Individuals may return immediately after close contact with an individual with confirmed COVID-19 if they do not have any symptoms consistent with COVID-19 and either they have tested positive for COVID-19 within the last 90 days or they are fully vaccinated against COVID-19. A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

[8] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

- Upon arrival, the student/parent/guardian, staff member, or essential 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 use of supplies, risk to screeners, and congregation of individuals while waiting to complete the temperature check upon arrival.

OR

- Physically check the student's, staff member's, or essential visitor's temperature upon their arrival at school.
    - The student/parent/guardian, staff member, or essential visitor uses a thermometer provided by the school and should follow the below protocol:
        - Maintain a distance of 6 feet from the person conducting the temperature check.
        - A non-contact thermometer is recommended. Forehead, tympanic (ear), or axillary (armpit) thermometers are also acceptable. Oral and rectal temperature checks should be avoided.
        - Thermometers should be cleaned per manufacturer instructions, including between uses.
        - *Student/family:* The student/parent/guardian should then check the student's temperature, after washing hands and wearing disposable gloves.
        - *Staff member or essential visitor*: The staff member or essential visitor should check their own temperature, after washing hands and wearing disposable gloves.
        - Any student, staff member, or essential visitor with a temperature of 100.4 degrees Fahrenheit or higher should not be admitted and should be instructed to call their healthcare provider to determine next steps. If the student, staff member, or essential visitor is not immediately able to leave the premises, they should be isolated from other individuals and wear a face mask; any accompanying staff member(s) should follow PPE guidance per the "suspected or confirmed COVID-19" section of Appendix B.
    - *If a Staff Member Takes Another Individual's Temperature:*
        - If a school staff member takes another individual's temperature at any point, they should follow CDC guidelines to do so safely, including with the use of barrier protection or Personal Protective Equipment (PPE), as articulated in Appendix A.

Symptoms While at School:
If a student or staff member develops any of the symptoms above during the school day, the school should have a process in place that allows them to isolate until it is safe to go home, and they should seek healthcare guidance. For more information, please see Section M. Exclusion, Dismissal, and Return to School Criteria.

Return to School Criteria:
To determine when a student or staff member may return to school, please see Section M. Exclusion, Dismissal, and Return to School Criteria.

F. FACE MASKS

All staff and essential visitors (including contractors), including those who are fully vaccinated, must wear face masks at all times while on school grounds, on school buses, and while participating in any school-related activities. A face mask may be a non-medical (cloth) face covering. If a staff member or essential visitor has a contraindication to wearing a face mask, either medical or otherwise, they should not participate in in-person school activities. Staff may wear face masks with clear plastic windows, or briefly remove their face masks, when interacting with students with disabilities identified as having hearing or vision impairments who require clear speech or lip-reading to access instruction.

Students, including those who are fully vaccinated, must also wear face masks while on school grounds, on school buses, and while participating in any school-related activities, except in the event of a medical or developmental contraindication. Most students, including those with disabilities, are able to wear face masks. Students who cannot safely wear a face mask, for example a student with a disability who is unable to remove the face mask without assistance if they have a breathing issue, should not be required to wear one and are entitled to education services. If a student participating in in-person activities is unable to wear a face mask throughout the day, mask breaks are acceptable at times in which physical (social) distance can be maintained (e.g., when outside) or during snacks or meals. Families and educators should work with students to practice wearing a mask safely and consistently.

Instances when face masks should not be worn:

- By children younger than 2 years of age;
- By anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance;
- By children during naptime; and
- When engaged in activities in which there is a risk of burn or injury from the use of a face covering—such as chemistry labs with open flame.

Face masks do not need to be worn:

- When actively drinking or eating a meal;
- When in the water in a swimming pool;
- When in an enclosed office that no one else is permitted to enter;
- When giving a speech for broadcast or an audience, provided no one is within 6 feet of the speaker;
- When speaking to or translating for a deaf or hard of hearing person; and
- When required to use equipment for a job that precludes the wearing of a mask and the person is wearing or using that equipment.

Schools should implement additional protocols to support the safe use of clean face masks.

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

- Face masks that are taken off temporarily to engage in any of the aforementioned activities should be carefully folded. The folded face mask can be stored in a plastic bag if it is wet or dirty or in a paper bag if it is not wet or dirty.
- When not being worn, face masks should be stored in a space designated for each student that is separate from others. They can also be placed next to the student on a napkin or directly on the desk/table if the surface is cleaned afterward.
- Student's face masks should also be clearly identified with their names or initials to avoid confusion or swapping. Students' face masks may also be labeled to indicate top/bottom and front/back.
- Students, teachers, and staff should be taught to speak more loudly, rather than remove their face mask, if speaking in a noisy environment.

Other populations:

- Parents/guardians must wear face masks for drop-off and pick-up.
- While visitors to the school should be limited, any essential visitor must wear a face mask at all times on the school grounds and inside the school buildings.

Please refer to DC Health's Masks and Cloth Face Coverings Guidance for the General Public for more details on face mask requirements for all District residents and visitors.

Face masks are recommended as a simple barrier to help prevent respiratory droplets from traveling into the air and onto other people when the person wearing the mask coughs, sneezes, talks, or raises their voice. This is called source control.

- Face masks protect the wearer and other people.
- To be effective, face masks must be worn correctly. Masks should be two to three layers of tightly woven fabric, cover the nose and mouth, and fit snugly against the sides of the face.
- A face mask is not a substitute for physical distancing.
- Face masks with exhalation valves or vents should NOT be worn in schools. This type of face mask does not prevent the person wearing the mask from transmitting COVID-19 to others (source control).
- Consider clear masks (not face shields) for students or staff who are deaf or hard of hearing.

Further guidance from CDC on the use of face masks, including information on types of masks, mask adaptations and alternatives, and instructions on how to store and wash masks, is available here and here.

G. HYGIENE

Hand Hygiene and Respiratory Etiquette

- Schools should reinforce frequent, proper handwashing strategies by staff and students, to include washing with soap and water for at least 20 seconds. If soap and water are not available and hands are not visibly dirty, use an alcohol-based hand sanitizer that contains at least 60 percent alcohol.
- Key times to perform hand hygiene include:
    - before and after eating food;

    - before and after group activities;
    - after going to the bathroom;
    - before and after putting on, touching, or removing face masks or touching your face;
    - after removing gloves; and
    - after blowing one's nose, coughing or sneezing.
- Schools should encourage staff and students to cover coughs and sneezes with a tissue when not wearing a mask. Used tissues should be thrown in the trash and hands washed immediately with soap and water for at least 20 seconds, or if soap and water is unavailable, cleaned with hand sanitizer.

School-wide Hygiene

- Schools should make available adequate supplies (e.g., soap, paper towels, hand sanitizer, tissues) to support healthy hygiene practices, including in classrooms, bathrooms, and offices. Schools are strongly encouraged to set up sanitizing stations outside of large common spaces including the gymnasium, cafeteria, and entrances/exits.
- Educators and staff that work in close contact with students, and/or that are working with any individual with suspected or confirmed COVID-19, should take extra steps and wear additional PPE, as articulated in Appendix B.

To the extent feasible, schools should:

- Make available adequate supplies to minimize sharing of high touch materials (e.g., avoid sharing electronic devices, toys, books, learning aids; assign each student their own art supplies or equipment). If shared supplies are used, limit use of supplies and equipment to one group of students at a time and clean between uses.
- Keep each student's belongings separated from others' and in individually labeled containers, cubbies, or areas.
- Encourage staff and students to bring their own water bottles and avoid touching or utilizing water fountains. If water fountains are used, they should be cleaned and sanitized frequently.
- Install no-touch fixtures: automatic faucets and toilets; touchless foot door openers, touchless trashcans; sensor water bottle fillers.

H. CLEANING AND DISINFECTION *[UPDATED]*

Routine Cleaning and Disinfection *[UPDATED]*

Schools should follow DC Health's Guidance on Cleaning and Disinfection for Community Facilities. In most situations, routine cleaning of surfaces once a day is adequate to prevent the spread of COVID-19 from surfaces. Schools should:

- Prioritize cleaning high-touch surfaces; at a minimum, high-touch surfaces should be cleaned at least once a day. This may include cleaning objects/surfaces not ordinarily cleaned daily (e.g., pens, counters, shopping carts, keyboards, elevator buttons, light switches, handles, stair rails, desks, faucets, sinks, phones, doors, and doorknobs).
- If a school determines that disinfection is needed, implement the following:
    - If the disinfectant product label does not specify that the product can be used for both cleaning and disinfection, clean visibly dirty surfaces with soap or detergent before disinfection.

    - Use Environmental Protection Agency (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), as recommended by the US EPA Design for Environment Program.
        - When EPA-approved disinfectants are not available, diluted household bleach can be used if appropriate for the surface. For detailed information see the CDC's Household Cleaning & Sanitizing.
    - Keep the surface wet with the disinfectant for the full amount of time recommended on the product label.
- For all products, follow the application instructions on the product label.
    - If diluting with water is indicated for use, use water at room temperature (unless stated otherwise on the label).
        - Label diluted cleaning or disinfectant solutions.
    - Do not mix products or chemicals.
    - Maintain good ventilation when using cleaning and disinfection products.
- Practice safe storage of all cleaning products, including storing and using chemicals out of the reach of children. See CDC's guidance for safe and correct application of disinfectants.
    - Avoid using cleaning products near students.
    - Students should not participate in disinfection.
    - *[UPDATED]* Custodial staff, as well as educators and other staff who may be cleaning and disinfecting spaces throughout the building, should wear gloves and adhere to other PPE best practices as articulated in Appendix B.
- Consider cleaning more frequently or routinely disinfecting (in addition to cleaning) items in shared spaces where there is high traffic, in spaces that are occupied by individuals at increased risk for severe illness from COVID-19, and in spaces occupied by young children or others who may not be diligent about wearing face masks and practicing good hand hygiene and respiratory etiquette.
- Limit the use of shared objects and equipment (e.g., gym or physical education equipment, art supplies, toys, games). If shared objects or equipment are used, to the extent feasible, clean between uses.
    - Shared toys, including those used indoors and outdoors should be frequently cleaned throughout the day.
        - Toys that have been in children's mouths or soiled by bodily secretions should be immediately set aside. These toys should be cleaned and sanitized by a staff member wearing gloves, before being used by another child.
        - Machine washable toys should be used by only one child and laundered in between uses.
    - Mats/cots and bedding should be individually labeled.
        - Bedding should be washable and washed whenever soiled or before use by another child. Unsoiled bedding should be washed weekly.
- Playground structures should be included as part of routine cleaning.
    - High-touch surfaces made of plastic or metal, such as grab bars, play structures, and railings, should be cleaned regularly.

- Cleaning and disinfection of wooden surfaces (such as wood play structures, benches, tables) or groundcovers (such as mulch and sand) is not recommended.
- Spraying cleaning products or disinfectants in outdoor areas – such as on sidewalks, roads, or groundcover – is not necessary, effective, or recommended.
- The CDC has guidance for cleaning various surfaces in playgrounds, available here.

- To the extent feasible, place signage in every classroom reminding staff of cleaning protocols.
- For shared bathrooms, assign a bathroom to each group of students and staff. If there are fewer bathrooms than the number of groups, assign each group to a particular bathroom, and, where feasible, clean bathrooms after each group has finished.
- Schools are strongly encouraged to develop and implement a schedule for increased routine cleaning. The CDC's Reopening Guidance for Cleaning and Disinfecting Public Spaces, Workplaces, Businesses, Schools, and Homes may be used as a resource.

Aerosol-Generating Procedures

- In the event a space in the school is used for an aerosol-generating procedure (e.g., tracheostomy suctioning or nebulized medication administration), that room should be only occupied by the student and staff member engaged in the treatment.
  - Students who receive nebulized treatments should be ***strongly encouraged*** to replace the nebulizer with oral inhalers whenever possible.
  - Schools are encouraged to work with families and the school nurse to identify opportunities to transition the schedule for tracheostomy suctioning and the administration of nebulized medication to before or after school, if medically appropriate.
  - If tracheostomy suctioning or nebulized medication is needed during the school day, schools should have well-ventilated rooms dedicated for this purpose, ideally each assigned for exclusive use by a given student, and if possible with windows open.
  - If assignment of a particular room to a particular student is not feasible, the room should be closed for 24 hours after the treatment to allow respiratory droplets to settle, then cleaned and disinfected prior to use by another individual.
  - Schools are strongly encouraged to provide nebulized treatments outside, if feasible and weather permitting.
  - Nurses and staff performing tracheostomy suctioning or nebulized medication administration should adhere to PPE best practices articulated in Appendix B.

Procedures after Suspected or Confirmed Cases of COVID-19 *[UPDATED]*

In accordance with DC Health's Guidance on Cleaning and Disinfection for Community Facilities, the following protocols including disinfection apply in circumstances in which a student, staff member, or essential visitor becomes ill with symptoms of COVID-19 or tests positive for COVID-19.

- *[UPDATED]* If a student, staff member, or essential visitor develops symptoms of or tests positive for COVID-19 **during the school day or within 24 hours of being in the building**, the school should clean and disinfect the area(s) where they have been.
  - *[UPDATED]* Schools should close areas where the sick individual has been.
    - If a COVID-19 case is confirmed during the day AND the COVID-19 positive individual is in the facility, then the cohort should be dismissed and the room vacated as soon as possible.

- It is acceptable for the cohort to remain in the room until the end of the day in the following circumstances:
    - If an individual has symptoms but is not confirmed to have COVID-19; or
    - If a COVID-19 case is confirmed and the COVID-19 positive individual has not been in the facility that day.
- Staff supporting, accompanying, or cleaning up after a sick student or staff member should adhere to PPE best practices as articulated in Appendix B.
- Once the room is vacated, schools should wait as long as possible before entering the room to clean and disinfect (at least several hours). Schools should perform cleaning and disinfection of the 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 student or staff member.
    - During cleaning and disinfection, schools should increase air circulation to the area (e.g., open doors, open windows, use fans, or adjust HVAC settings).
    - *[UDPATED]* Staff must wear a face mask for all steps of the cleaning and disinfection process. Staff should also wear gloves and follow additional PPE best practices as articulated in Appendix B.
    - For additional material-specific considerations, including for soft surfaces, laundry, electronics, and outdoor areas, see DC Health's Guidance on Cleaning and Disinfection for Community Facilities with Suspected or Confirmed COVID-19.

- *[UPDATED]* If a student, staff member, or essential visitor develops symptoms of or tests positive for COVID-19 and it has been **more than 24 hours, but less than three days**, since the individual was in the school building, the school should clean any areas where the individual has been. Disinfection is not necessary.
- If a student, staff member, or essential visitor develops symptoms of or tests positive for COVID-19 and it has been **more than three days** since the individual was in the building, no special cleaning and disinfection procedures are necessary, and the school should follow routine cleaning and disinfection procedures.

I. STUDENTS WITH DISABILITIES

This section articulates specific considerations that may be relevant to serving students with disabilities, and/or other students with particular needs. Additional considerations of relevance to serving this population are included throughout the document.

Throughout this period, LEAs should design educational programming to conform with CDC, DC Health, and OSSE guidance, and in doing so, consideration should be given to a student's 504 plan, IEP and least restrictive environment (LRE). LEAs should continue to provide, to the greatest extent possible, the special education and related services identified in students' IEPs and the accommodations and related services identified in students' 504 Plans (OSEP Guidance A-1). Regardless of the severity of a student's disability, LEAs should make every effort to enable full participation of students with disabilities in building activities and to mitigate factors that could discourage participation, such as cost and accessibility. LEAs are reminded of their responsibility to ensure that students with disabilities are educated to the greatest extent possible with their nondisabled peers (34 CFR §300.114). For additional information on the flexibilities available under IDEA for service delivery please see OSSE IDEA Part B

Provision of FAPE: Guidance Related to Remote and Blended Learning. LEAs are also reminded of their obligations to uphold the rights of individuals with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, and the DC Human Rights Act.

If a student with a disability is excluded from school, the school is required to provide services consistent with all applicable disability laws.

J. HIGH-RISK INDIVIDUALS

Schools should notify all families and staff that DC Health recommends that any individual at increased risk for experiencing severe illness due to COVID-19 should consult with their healthcare provider ***before*** attending in-person activities at school. This includes, but is not limited to, older adults and people with the following conditions:

- Cancer
- Chronic kidney disease
- Chronic lung diseases, including COPD (chronic obstructive pulmonary disease), asthma (moderate-to-severe), interstitial lung disease, cystic fibrosis, and pulmonary hypertension
- Dementia or other neurological conditions
- Diabetes (type 1 or type 2)
- Down syndrome
- Heart conditions (such as heart failure, coronary artery disease, cardiomyopathies, or hypertension)
- HIV infection
- Immunocompromised state (weakened immune system)
- Liver disease
- Overweight and obesity
- Pregnancy
- Sickle cell disease or thalassemia
- Smoking, current or former
- History of solid organ or blood stem cell transplant
- History of stroke or cerebrovascular disease
- Substance use disorders

There is less evidence to date about conditions which put children at increased risk of severe illness from COVID-19. Current information suggests that children with medical complexity (like genetic, neurologic, or metabolic conditions, and congenital heart disease) are generally at increased risk compared to their healthier peers. Like adults, conditions such as obesity, diabetes, asthma or chronic lung disease, sickle cell disease, or immunosuppression also appear to put children at increased risk for severe COVID-19.

Information from the CDC for older adults is available here. A complete list of conditions that might place an individual at increased risk of severe illness from COVID-19 can be found here. Any student or staff member who has a medical condition not listed but who is concerned about their safety is recommended to consult with their healthcare provider before attending in-person activities.

Schools are not required to secure written clearance from high-risk individuals prior to participating in in-person activities at school.

K. MEALS

Schools must follow all applicable federal and local food safety requirements. Additional meal service guidance from OSSE is available here. Further guidance for school nutrition professionals is available from the CDC here. Additionally, schools should follow the below recommendations.

All schools should serve meals following the physical (social) distancing and hygiene guidance.

- Students should wash hands before and after eating and should not share utensils, cups, or plates.
- Staff should wash hands before and after helping students to eat.
- Foodservice staff should follow all PPE best practices in Appendix B
- Tables and chairs should be cleaned and sanitized before and after each meal.
- Schools should routinely clean and disinfect surfaces and objects that are frequently touched, such as kitchen countertops, cafeteria and service tables, door handles, carts, and trays.

Meal Distribution

- To the extent feasible, schools should allow students to eat lunch and breakfast in their classrooms rather than mixing in the cafeteria. If not possible, then schools should stagger lunch by class and/or divide eating area by class, cleaning and sanitizing between groups.
- Schools should consider outdoor options for students to eat lunch and breakfast.
- Schools should prepackage meals, including silverware, napkins, and seasonings, or serve meals individually plated, while ensuring the safety of students with food allergies.
- To the extent feasible, if schools are providing grab-and-go meals to families, school should implement a plan for curbside pickup of meals or contactless delivery service to minimize contacts with students and their families.
- Schools should not allow food preparation booths or sampling of food.
- Schools should cease use of any food or beverage self-service stations, such as hot bars and salad bars, not including whole product.

Meal Service

- Schools should use disposable food service items (e.g., utensils, dishes). If disposable items are not feasible or desirable, schools should implement procedures for all non-disposable food service items to be either manually washed, rinsed, and sanitized in a three-compartment sink or in a dishwasher. Individuals should wash their hands after removing their gloves or after directly handling used food service items.
- If food is offered at any event, schools should have pre-packaged boxes or bags for each attendee instead of a buffet or family-style meal.
- Students may bring lunches from home. Schools are encouraged to keep each student's belongings, such as lunches, separated from others' and in individually labeled containers, cubbies, or areas. Communication with families about cleaning items brought from home is recommended.

- Schools must ensure adherence to students' 504 Plans, if applicable, and Anaphylaxis Action Plans, including ensuring that students are not exposed to foods to which they are allergic.

L. RESIDENTIAL SCHOOLS

Schools with a residential component (i.e., boarding schools) should implement all the safety measures throughout this guidance in the residential setting.

Additionally, the following safety measures are recommended:

- No more than two students per residential room with a strong preference of one student per residential room;
- Compliance with DC Health's Guidance for Travel;
- Designation of private rooms with dedicated bathrooms for any students who may test positive for COVID-19;
- Designation of private rooms with dedicated bathrooms for any close contacts of confirmed cases of COVID-19 (this area should be separate from the isolation area);
- Testing access for students showing symptoms of COVID-19 or with known exposure to individuals with COVID-19;
- Appropriate and easy access to medical services for COVID-19 related and non-COVID-19 related conditions; and
- Plan and capability to restrict or eliminate in-person activities rapidly in the case of significant community transmission or identified outbreak of COVID-19, including indications and procedures for closure of residential halls and dormitories.

RESPONSE

M. EXCLUSION, DISMISSAL, AND RETURN TO SCHOOL CRITERIA AND PROTOCOLS

*S*chools should adhere to the below exclusion, dismissal, and return to school criteria and protocols.

Exclusion Criteria

A student, staff member, or essential visitor **must stay home, or not be admitted,** and must follow the applicable DC Health guidance for isolation or quarantine, if they:

- Have had a temperature of 100.4 degrees Fahrenheit or higher or any of the symptoms listed above in the "Daily Health Screening" section of this guidance in the last 24 hours.
- Are confirmed to have COVID-19.
- Have been in close contact in the last 10 days with an individual confirmed to have COVID-19.[9]

[9] Returning to school after 10 days is intended to minimize the risk of transmission of the virus while also minimizing the burden. DC Health guidance allows for schools to continue to implement the more stringent 14-day return to school recommendation if they choose to. Waiting 14 days before returning to school remains the most effective strategy for decreasing the transmission of COVID-19. DC Health strongly recommends that individuals who live or work with someone at higher-risk for COVID-19 (see Section I) quarantine for 14 days.

- Are awaiting COVID-19 test results or have a household member who is awaiting COVID-19 test results.[10]
- Have traveled domestically in the last 10 days to any place other than Maryland or Virginia, unless they did not attend school until tested for COVID-19 three to five days after returning to DC AND received a negative COVID-19 viral test.[11]
- Have traveled internationally in the last 10 days, unless they did not attend school for seven days, got tested for COVID-19 three to five days after returning to DC, AND received a negative COVID-19 viral test.[12]

Students or staff with pre-existing health conditions that present with specific COVID-19-like symptoms must not be excluded from entering the school building on the basis of those specific symptoms if a healthcare provider has provided written or verbal documentation that those specific symptoms are determined to not be due to COVID-19.

Provided that they do not currently have any symptoms consistent with COVID-19, an individual who has **tested positive for COVID-19 within the last 90 days or is fully vaccinated** may be admitted while awaiting COVID-19 test results, after close contact with someone with confirmed COVID-19, when a household contact is awaiting COVID-19 test results, or after travel.[13] Any individual with symptoms consistent with COVID-19 must follow the exclusion criteria outlined above.

Provided that they do not currently have any symptoms consistent with COVID-19, an individual who **has tested positive for COVID-19 in the last 90 days or is fully vaccinated** against COVID-19 may be admitted immediately after domestic or international travel. They should get a COVID-19 test three to five days after international travel.[14] Any individual with symptoms consistent with COVID-19 must follow the exclusion criteria outlined above.

If excluded, students (or their parents/guardians), staff, and essential visitors should call their healthcare provider for further directions.

DC Health recommends that students and staff should get tested for COVID-19 if anyone in their household has symptoms of COVID-19, even if the student or staff member themself does not have symptoms. All members of the household should be tested at the same time. Individuals who are fully

[10] This exclusion criterion does not apply in the circumstance of awaiting the result of a test administered through the DC Health asymptomatic testing program in schools and or other formal screening or surveillance testing programs. Per DC Health, schools that are participating in a formal screening or surveillance testing program as part of the broader policy of an umbrella organization should defer to the testing policy of their umbrella organization. Schools wishing to implement a formal screening or surveillance program in consultation with their health services provider should develop and share a testing plan with the Deputy Mayor for Education and OSSE teams at EdSupport@dc.gov.

[11] For more detailed guidance related to returning from domestic and international travel, see DC Health's Guidance for Travel.

[12] For more detailed guidance related to returning from domestic and international travel, see DC Health's Guidance for Travel.

[13] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

[14] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

vaccinated against COVID-19 should only get tested in this instance if they develop symptoms.[15]

Dismissal Criteria and Protocols

If a student, staff member, or essential visitor develops a fever or other signs of illness, the school must follow the above exclusion criteria regarding the exclusion and dismissal of students, staff, and essential visitors.

- For students, the school should:
    - Immediately isolate the student from other students.
        - The student should immediately put on a face mask or surgical mask, if not wearing already.
        - Identify a staff member to accompany the isolated student to the isolation area and supervise the student while awaiting pickup from the parent/guardian.
        - The staff members briefly responding to the sick student in the classroom, accompanying the student to the isolation area, and supervising the student in the isolation area should comply with PPE best practices per Appendix B.
    - Additionally, schools should:
        - Notify the student's parent/guardian of the symptoms and that the student should be picked up as soon as possible and instruct them to seek healthcare provider guidance.
        - Follow guidance for use of the isolation room below.
        - Immediately follow all cleaning and disinfection protocols for any area and materials with which the student was in contact, per Section H: Cleaning and Disinfection.
- For staff and essential visitors, the school should:
    - Send the staff member or essential visitor home immediately or instruct them to isolate until it is safe to go home;
    - Instruct the staff member or essential visitor to seek healthcare provider guidance; and
    - Follow cleaning and disinfecting procedures for any area, materials, and equipment with which the staff member was in contact.

Isolation Room: Schools should identify more than one well-ventilated space to isolate sick individuals until they are able to leave the school grounds. The space should be in an area that is not frequently passed or used by other students or staff, is not simply behind a barrier in a room being utilized by other individuals and is not the health suite. If safe and weather permitting, schools are encouraged to isolate sick individuals outdoors under appropriate supervision. When in the isolation area, the sick individual should always wear a face mask or surgical mask, be within sight of the supervising staff member, and be physically separated from other individuals by at least 6 feet. Schools should isolate only one sick individual in the isolation area at a time. The isolation area should be immediately cleaned and disinfected after the sick individual departs. Supervising staff should comply with the PPE best practices in Appendix B.

Return Criteria

Table 1 below identifies the criteria that schools should use to allow the return of a student or staff member with: (1) COVID-19 symptoms; (2) positive COVID-19 test results; (3) negative COVID-19 test results; (4) documentation from healthcare provider of alternate diagnosis; (5) close contact with an

[15] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

individual with confirmed COVID-19; (6) a household member awaiting COVID-19 test results; or (7) travel to any place other than Maryland or Virginia.

For all scenarios, individuals must follow applicable DC Health guidance for isolation and quarantine.

Table 1. Return to School Criteria for Students and Staff

Student or Staff Member With:	Criteria to Return *Note: Criteria below represent standard criteria to return to care. In all cases, individual guidance from DC Health or a healthcare provider would supersede these criteria.*
1. COVID-19 symptoms (e.g., fever, cough, difficulty breathing, loss of taste or smell)	Recommend the individual seek healthcare guidance to determine if COVID-19 testing is indicated. If the individual is tested: • If positive, see #2. • If negative, see #3. • Individuals must not attend school while awaiting test results. If the individual does not complete test, they should: • Submit documentation from a healthcare provider of an alternate diagnosis, and meet standard criteria to return after illness; OR • Meet symptom-based criteria to return: o At least 24 hours **after** the fever has resolved without the use of fever-reducing medication (e.g., Motrin, Tylenol) and symptoms have improved; AND o At least 10 days from when symptoms first appeared, whichever is later. Note: Students or staff with pre-existing health conditions that present with specific COVID-19-like symptoms must not be excluded from entering the school building on the basis of those specific symptoms, if a healthcare provider has provided written or verbal documentation that those specific symptoms are not due to COVID-19. Note: Standard criteria to return after illness refers to the individual school's existing policies and protocols for a student or employee to return to school after illness. DC Health recommends that students and staff should get tested for COVID-19 if anyone in their household has symptoms of COVID-19, even if the student or staff member themself does not have symptoms. All members of the household should be tested at the same time. Individuals who are fully vaccinated against COVID-19 should only get tested in this instance if they

	develop symptoms.[16]
2. Positive COVID-19 Test Result (Antigen or PCR) *See DC Health's Guidance for Persons Who Tested Positive for COVID-19 for more information.*	If symptomatic, may return after: • At least 24 hours **after** the fever has resolved without the use of fever-reducing medication (e.g., Motrin, Tylenol) and symptoms have improved; AND • At least 10 days after symptoms first appeared, whichever is later. If asymptomatic, may return after: • 10 days from positive test Regardless of whether symptomatic or asymptomatic, close contacts (including all members of the household) who are not fully vaccinated against COVID-19 must not attend school for at least 10 days from the last date of close contact with the positive individual.
3. Negative COVID-19 Test Result After Symptoms of COVID-19	May return when: • Meet standard criteria to return after illness. • If the individual received a negative antigen test, that result should be confirmed with a negative PCR test. The individual must not attend school until the PCR test result returns. Note: Standard criteria to return after illness refers to the individual school's existing policies and protocols for a student or employee to return to school after illness. *Per Scenario #5, a negative test result after close contact with an individual with confirmed COVID-19 should *not* shorten the time period of at least 10 days before returning to school.
4. Documentation from Healthcare Provider of Alternate Diagnosis After Symptoms of COVID-19 (e.g., chronic health condition, or alternate acute diagnosis such as strep throat)	May return when: • Meet standard criteria to return after illness. Note: Standard criteria to return after illness refers to the individual school's existing policies and protocols for a student or employee to return to school after illness.
5. Close Contact of an Individual with Confirmed COVID-19	May return after: • A minimum of 10 days from last exposure to COVID-19 positive individual, provided that no symptoms develop, or as instructed by DC Health.

[16] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

See DC Health's Guidance for Quarantine after COVID-19 Exposure for more information	Note: Returning to school after 10 days (on day 11) is only acceptable if: • The close contact did not develop symptoms of COVID-19 at any point during the 10 days. AND • The close contact continues to self-monitor for symptoms until 14 days after the last exposure to the COVID-19 positive individual. If the close contact is a household member, may return after at least 10 days from the end of the COVID-19 positive individual's infectious period (see Scenario #2), or as instructed by DC Health. Returning to school after 10 days is intended to minimize the risk of transmission of the virus while also minimizing the burden. DC Health guidance allows for schools to continue to implement the more stringent 14-day return to school recommendation if they choose to. Waiting 14 days before returning to school remains the recommended and most effective strategy for decreasing the transmission of COVID-19. DC Health strongly recommends that individuals who live or work with someone at higher-risk for COVID-19 (see Section I) quarantine for 14 days. DC Health recommends that students and staff should get tested for COVID-19 if anyone in their household has symptoms of COVID-19, even if the student or staff member themself does not have symptoms. All members of the household should be tested at the same time. Individuals who are fully vaccinated against COVID-19 should only get tested in this instance if they develop symptoms.[17] Individuals may return immediately after close contact with an individual with confirmed COVID-19 if the following are true: • They do not have any symptoms consistent with COVID-19. AND • They have tested positive for COVID-19within the last 90 days; OR • They are fully vaccinated against COVID-19.[18]
6. Household Member Awaiting a	If the household member tests negative: • May return immediately if the student or staff member has no symptoms of COVID-19 nor other exclusionary criteria met. If the household member tests positive:

[17] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).
[18] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

COVID-19 Test Result[19]	• See Scenario #5. Individuals may return immediately in the event of a household member awaiting a COVID-19 test result if the following are true: • They do not have any symptoms consistent with COVID-19. AND • They have tested positive for COVID-19 within the last 90 days; OR • They are fully vaccinated against COVID-19.[20]
7. Travel to Any Place Other than Maryland or Virginia *See DC Health's Guidance for Travel and the CDC's COVID-19 Travel Recommendations by Destination for more information*	If the individual is unvaccinated or partially vaccinated, may return from domestic travel after: • 10 days from return. OR • Being tested for COVID-19 three to five days after return and receiving a negative result. If the individual is unvaccinated or partially vaccinated, may return from international travel after: • 10 days from return. OR • Seven days, if tested for COVID-19 three to five days after return, and received a negative result. o Even if the test is negative, the individual must not attend school for seven days. If the individual has tested positive for COVID-19 in the last 90 days or is fully vaccinated,[21] may return immediately after domestic or international travel, provided that they do not currently have any symptoms consistent with COVID-19. • If the individual is returning from international travel, they should get a COVID-19 test three to five days after traveling. For more detailed guidance related to returning from domestic and international travel, see DC Health's Guidance for Travel.

[19] This guidance does not apply in the circumstance of awaiting the result of a test administered through the DC Health asymptomatic testing program in schools and or other formal screening or surveillance testing program. Per DC Health, schools that are participating in a formal screening or surveillance testing program as part of the broader policy of an umbrella organization should defer to the testing policy of their umbrella organization. Schools wishing to implement a formal screening or surveillance program in consultation with their health services provider should develop a testing plan and share that plan with the Deputy Mayor for Education and OSSE teams at EdSupport@dc.gov.

[20] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

[21] A person is considered fully vaccinated 14 days after completion of a COVID-19 vaccination series (after the second dose of a two-dose series, or after one dose of a single-dose vaccine).

Implement Leave Policies for Staff

Schools should implement leave policies that are flexible and non-punitive and allow sick employees to stay home.

- Leave policies are recommended to account for the following:
    - Employees who report COVID-19 symptoms;
    - Employees who were tested for COVID-19 for reasons including symptoms, travel, or exposure and test results are pending;
    - Employees who tested positive for COVID-19;
    - Employees who are a close contact of someone who tested positive for COVID-19; and
    - Employees who need to stay home with their children if there are school or child care closures, or to care for sick family members.
- Keep abreast of current law, which has amended both the DC Family and Medical Leave Act and the DC Sick Leave Law and created whole new categories of leave, such as Declared Emergency Leave.
- Learn about and inform your employees about COVID-19-related leave provided through new federal law, the Families First Coronavirus Response Act (FFCRA), and all applicable District law relating to sick leave.

N. EXPOSURE REPORTING, NOTIFICATIONS, AND DISINFECTION *[UPDATED]*

To ensure a clear and efficient process for communication each school must 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 school has contact information for all contract staff. It is critical that DC Health have 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 student or staff member tests positive for COVID-19.

Step 1: Reporting to DC Health

Refer to DC Health's First Steps for Non-Healthcare Employers when Employees Test Positive for COVID-19.

Schools must notify DC Health when:

- A staff member or essential visitor notifies the school they **tested positive for COVID-19** (not before results come back);

OR

- A student or parent/guardian notifies the school that a student **tested positive for COVID-19** (not before results come back).

AND

- The individual was on school grounds or participated in school activities **during their infectious period**.
    - The infectious period starts two days before symptom onset date (or positive test date for people who do not have symptoms) and typically ends 10 days after symptom onset

date (or positive test date for people who do not have symptoms).

As soon as possible on the same day the case was reported to the school, the school must 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) under the section "Non-Healthcare Facility Establishment Reporting."

- Select "Non-Healthcare Facility COVID-19 Consult Form."

An investigator from DC Health will follow up within 24 hours to all appropriately submitted notifications. Please note this time may increase as cases of COVID-19 increase in the District.

Note: While schools await a response from DC Health, plans should be made as soon as practical to close, clean, and disinfect, as necessary, any areas or equipment that the COVID-19 positive individual may have used (see Step 3).

Step 2: Communication to Families and Staff
Schools should have communication protocols in place that protect the privacy of individuals and alert families and staff to a COVID-19 case. DC Health will identify close contacts based on its case investigation. Communication should be completed per DC Health directive and should include:

- Notification to the entire school or the affected classroom(s) that there was a COVID-19 positive case, those impacted will be notified and told they must not attend school, and steps that will be taken (e.g., cleaning and disinfection);
- Education about COVID-19, including the signs and symptoms, available at coronavirus.dc.gov;
- Referral to the Guidance for Contacts of a Person Confirmed to have COVID-19, available at coronavirus.dc.gov/healthguidance; and
- Information on options for COVID-19 testing in the District of Columbia, available at coronavirus.dc.gov/testing.

DC Health will instruct schools on dismissals and other safety precautions in the event a known COVID-19 individual came in close contact with others at school. DC Health will determine which individuals are close contacts who should be instructed to not attend school for at least 10 days, but schools do not need to wait to hear from DC Health before informing school communities of a known positive case.

If a school identifies a student or staff member with COVID-19 who is in the building, schools should be prepared to dismiss the potentially exposed cohort(s) and they must not attend school until DC Health is able to complete the case investigation.

- The exposed cohort should remain in their classroom and follow routine procedures while they are waiting for their caregivers to pick them up.
- If the school is notified of a case who is not in the building, the affected cohort may remain until the end of the school day.

***[UPDATED]* Step 3: Cleaning and Disinfection of Affected Spaces**
In the event of a confirmed COVID-19 case in a student, staff member, or essential visitor, the school should follow DC Health's Guidance on Cleaning and Disinfection for Community Facilities as well as the cleaning and disinfection guidance from the CDC, linked here:

- *[UPDATED]* If the COVID-19 positive individual has been in the school building **within the past 24 hours**, the school should clean and disinfect the area(s) where the sick individual has been.
    - *[UPDATED]* Schools should close off areas where the sick individual has been.
        - If a COVID-19 case is confirmed during the day AND the COVID-19 positive individual is in the facility, then the cohort should be dismissed and the room vacated as soon as possible.
        - If the COVID-19 positive individual has not been in the building that day, then it is acceptable to remain in the room until the end of the day.
    - Staff supporting, accompanying, or cleaning up after a sick child should adhere to PPE best practices as articulated in Appendix B.
    - Once the room is vacated, schools should wait as long as possible before entering the room to clean and disinfect (at least several hours). Schools should perform 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 student or staff member.
        - During cleaning and disinfection, schools should increase air circulation to the area (e.g., open doors, open windows, use fans, or adjust HVAC settings).
        - *[UPDATED]* Staff must wear a face mask for all steps of the cleaning and disinfection process. Staff should also wear gloves and follow additional PPE best practices as articulated in Appendix B.
        - For additional material-specific considerations, including for soft surfaces, laundry, electronics, and outdoor areas, see DC Health's Guidance on Cleaning and Disinfection for Community Facilities with Suspected or Confirmed COVID-19.
- *[UPDATED]* If it has been **more than 24 hours but less than three days** since the COVID-19 positive individual was in the school building, the school should clean any areas where the individual has been. Disinfection is not necessary.
- If it has been **more than three days** since the COVID-19 positive individual was in the building, no special cleaning and disinfection procedures are necessary, and the school should follow routine cleaning and disinfection procedures.

PROCESS TO REVIEW REOPENING PLANS

All LEAs and private, parochial, and independent schools are required to submit a plan to the Office of the State Superintendent of Education (OSSE) that describes how they will safely reopen schools in accordance with this health and safety guidance. OSSE will designate clear timelines and intervals for plan submission and ensure a complete review of reopening plans for all DC public and public charter LEAs and private, parochial, and independent schools. As needed, individual plan reviews will include follow-up actions on areas of concern. Plans must be made publicly available at least 10 days prior to reopening.

QUESTIONS?

If you have questions related to this guidance, contact the OSSE Division of Health and Wellness at OSSE.HealthandSafety@dc.gov.

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

APPENDIX A: PROCEDURE FOR STAFF CONDUCTING PHYSICAL TEMPERATURE CHECKS

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

In the event a staff member is taking another individual's temperature, they should follow one of two options articulated below, per guidance from the Centers for Disease Control and Prevention (CDC), to do so safely. During temperature checks, use of barriers or personal protective equipment (PPE) helps to eliminate or minimize exposures due to close contact with a person who has symptoms. Use of non-contact thermometers is strongly encouraged.

OPTION 1: Barrier/partition controls

- **Wash hands** with soap and water for 20 seconds. If soap and water are not available, use a hand sanitizer with at least 60 percent alcohol.
- **Put on** disposable gloves.
- **Stand behind a physical barrier**, such as a glass or plastic window, or partition that can serve to protect the staff member's eyes, nose, and mouth from respiratory droplets if the person being screened sneezes, coughs, or talks.
- **Make a visual inspection** of the individual for signs of illness, which include flushed cheeks, rapid breathing (without recent physical activity), fatigue, or extreme fussiness.
- **Check the temperature, reaching around the partition or through the window.**
    - Always make sure your face stays behind the barrier during the temperature check.
- If performing a **temperature check on multiple individuals:**
    - Use a **clean pair of gloves for each individual** and that the **thermometer has been thoroughly cleaned** in between each check.
    - If you use disposable or non-contact thermometers and you did not have physical contact with the individual, you do not need to change gloves before the next check.
- **Remove your gloves** following proper procedures.
- **Wash hands** with soap and water for 20 seconds. If soap and water are not available, use a hand sanitizer with at least 60 percent alcohol.
- **Clean the thermometer** following the directions below.

OPTION 2: Personal Protective Equipment (PPE)

- PPE can be used if a temperature check cannot be performed by a parent/guardian (for a child), or an older student, staff member, or essential visitor for him/herself *or* barrier/partition controls cannot be implemented.
- The CDC states that reliance on PPE is less effective and more difficult to implement because of PPE shortages and training protocols.
- If staff do not have experience in using PPE, the CDC has recommended sequences for donning and doffing PPE.
- To follow this option staff should:
    - **Wash hands** with soap and water for 20 seconds. If soap and water are not available, use a hand sanitizer with at least 60 percent alcohol.

- **Put on PPE.** This includes a surgical face mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face), and a single pair of disposable gloves. A gown/coverall (e.g., large, button-down, long-sleeved shirt) should be considered if extensive contact with the individual being screened is anticipated.
- **Take** the individual's **temperature**.
- If performing a **temperature check on multiple individuals:**
  - Use a **clean pair of gloves for each individual** and that the **thermometer has been thoroughly cleaned** in between each check.
  - If you use disposable or non-contact thermometers and you did not have physical contact with the individual, you do not need to change gloves before the next check.
- **Remove and discard PPE**.
- **Wash hands** with soap and water for 20 seconds. If soap and water are not available, use a hand sanitizer with at least 60 percent alcohol.

- **Clean the thermometer** following the directions below.

APPROPRIATE USE OF THERMOMETERS, INCLUDING HYGIENE AND CLEANING PRACTICES:

- Use of non-contact thermometers is highly encouraged. Forehead, tympanic (ear), or axillary (armpit) thermometers are also acceptable. Oral and rectal temperature checks should be avoided.
- Thoroughly clean the thermometer before and after each use per manufacturer instructions.
- If you use non-contact thermometers, clean them with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual screened. You can reuse the same wipe as long as it remains wet.

APPENDIX B: PPE BEST PRACTICES FOR SCHOOL STAFF *[UPDATED]*

School staff should adhere to the guidance below at a minimum. These guidelines do not replace professional judgment, which should always be used to support the safest environment for staff and students.

Note: Staff and students should practice good hand hygiene throughout all the scenarios and maintain physical distance of 6 feet to the maximum extent feasible.

Wearing gloves is not a substitute for good hand hygiene. Gloves should be changed between students and care activities, and hand hygiene should be performed between glove changes. If skin comes into contact with any secretions or bodily fluids, it should be immediately washed. Contaminated clothing should be immediately removed and changed.

WORKING WITH STUDENTS WHO ARE <u>NOT KNOWN OR NOT SUSPECTED</u> TO HAVE COVID-19

Lower Risk:[22] *Six feet of physical distance cannot always be maintained. Close contact with secretions or bodily fluids is not anticipated.*

- Face mask (A face mask may be a non-medical [cloth] face covering)

Medium Risk:[23] *Staff are in close/direct contact with less than 6 feet of physical distance from the student. Close contact with secretions or bodily fluids is possible or anticipated.*

- Face mask
    - If potential for bodily fluids to be splashed or sprayed (e.g., student who is spitting, coughing), use surgical mask and eye protection (face shield or goggles) instead of non-medical (cloth) face covering.
- Gown/coverall (e.g., large, button-down, long-sleeved shirt)
- Gloves must be used per existing procedures (e.g., when diapering, administering medication)

[22] Scenarios that would be classified as "lower risk" include situations where school staff may be within 6 feet of students who are not known or suspected to have COVID-19 *and* in which the students are not consistently wearing their face masks. This includes services by related service providers in which close contact with secretions is not anticipated. This also includes scenarios in which staff administering the Daily Health Screening are wearing a face mask, maintain 6 feet of physical distance *and* are <u>not</u> performing a physical temperature check.

[23] Scenarios that would be classified as "medium risk" include close contact between a student and a related service provider, paraprofessional and/or dedicated aide in which close contact with secretions or bodily fluids is possible or anticipated. This also includes personal care (e.g., diapering) and oral medication administration.

Higher Risk: *Staff are in close/direct contact with less than 6 feet of physical distance from the student and performing a higher-risk or aerosol generating procedure, including administration of nebulized medication.*[24]

- N95 mask (with access to Respirator Fit Testing program)[25]
- Eye protection (face shield or goggles)
- Gown/coverall
- Gloves

WORKING WITH STUDENTS WHO ARE KNOWN OR SUSPECTED TO HAVE COVID-19

Staff working with any student who is known to have COVID-19 or who is exhibiting symptoms of COVID-19 should take additional steps.

While responding briefly to a sick student, or while escorting a sick student to the isolation room:

- If the student is wearing a face mask and is able to maintain 6 feet of distance, accompanying staff should wear:
    - Face mask
- If the student is not wearing a face mask or is not able to maintain 6 feet of distance, accompanying staff should wear:
    - Surgical mask
    - Eye protection (face shield or goggles)
    - Gown/coverall
    - Gloves

While supervising a sick student in the isolation room, staff should always wear:

- Surgical mask
- Eye protection (face shield or goggles)
- Gown/coverall
- Gloves
- *Note:* The student in the isolation room should also wear a face mask *or* surgical mask.

The sick student and any staff accompanying or supervising them to/in the isolation room should safely remove and store their face mask, or dispose of their surgical mask, after use.

[24] Per the Centers for Disease Control and Prevention, aerosol-generating procedures include administering nebulized medication, open suctioning of airways, sputum induction, cardiopulmonary resuscitation, endotracheal intubation and extubation, non-invasive ventilation (e.g., BiPAP, CPAP), bronchoscopy, and manual ventilation. More information can be found here.

[25] Any individual using an N95 mask must have access to a comprehensive Respirator Fit Testing program. An individual who has not completed a Respirator Fit Testing program must NOT wear an N95 nor participate in higher-risk scenarios. For additional information, see the Occupational Safety and Health Administration's Occupation Safety and Health Standards for respiratory protection.

PPE FOR STAFF WITH SPECIFIC ROLES

Staff Administering a COVID-19 Test

- N95 mask (with access to Respirator Fit Testing program)[26]
- Eye protection (face shield or goggles)
- Gown/coverall
- Gloves

[UPDATED] **Custodial Staff**

- Face mask
    - If there is an increased risk of exposure to COVID-19 (e.g., cleaning an area occupied by an individual with symptoms of COVID-19), wear surgical mask instead of non-medical (cloth) face covering.
- Gown/coverall
- Gloves
- Other PPE, including eye protection and respiratory protection, may be recommended based on cleaning/disinfectant products being used and whether there is a risk of splash. Follow all product instructions on the product's safety data sheets (SDS). For more information, visit the CDC's website here.

Classroom educators and staff who are cleaning and disinfecting areas or equipment utilized by a sick individual should follow Custodial Staff guidelines above. Classroom educators and staff doing routine cleaning (e.g., of high-touch surfaces) must wear a face mask. Other PPE may be recommended based on cleaning/disinfectant products being used and whether there is a risk of splash. For more information, visit the CDC's website here.

Foodservice Staff

- Face mask
- Gloves (when handling food products)
- Additional PPE may be required per food preparation regulation and requirements

Performing Physical Temperature Check: per Appendix A

[26] Any individual using an N95 mask must have access to a comprehensive Respirator Fit Testing program. An individual who has not completed a Respirator Fit Testing program must NOT wear an N95 nor administer a COVID-19 test. For additional information, see the Occupational Safety and Health Administration's Occupation Safety and Health Standards for respiratory protection.

APPENDIX C: COVID-19 TESTING

DEFINITIONS

For information about each type of testing, see DC Health's resource Coronavirus 2019 (COVID-19): PCR, Antigen, and Antibody Tests.

Diagnostic testing for SARS-CoV-2 is intended to identify occurrence at the individual level and is performed when there is a reason to suspect that an individual may be infected, such as having symptoms or suspected recent exposure, or to determine resolution of infection. Examples of diagnostic testing include testing symptomatic individuals who present to their healthcare provider, testing individuals through contact tracing efforts, testing individuals who indicate that they were exposed to someone with a confirmed or suspected case of coronavirus disease 2019 (COVID-19), and testing individuals present at an event where an attendee was later confirmed to have COVID-19.[27]

Screening tests for SARS-CoV-2 are intended to identify occurrence at the individual level even if there is no reason to suspect infection—e.g., there is no known exposure. This includes, but is not limited to, screening of non-symptomatic individuals without known exposure with the intent of making decisions based on the test results. Screening tests are intended to identify infected individuals without, or prior to development of, symptoms who may be contagious so that measures can be taken to prevent further transmission. Examples of screening include testing plans developed by a workplace to test its employees, and testing plans developed by a school to test its students, faculty, and staff. In both examples, the intent is to use the screening testing results to determine who may return and the protective measures that will be taken.[28]

Surveillance for SARS-CoV-2 includes ongoing systematic activities, including collection, analysis, and interpretation of health-related data that are essential to planning, implementing, and evaluating public health practice. Surveillance testing is generally used to monitor for a community- or population-level occurrence, such as an infectious disease outbreak, or to characterize the occurrence once detected, such as looking at the incidence and prevalence of the occurrence. Surveillance testing is used to gain information at a population level, rather than an individual level, and results of surveillance testing can be returned in aggregate to the requesting institution. Surveillance testing may sample a certain percentage of a specific population to monitor for increasing or decreasing prevalence and to determine the population effect from community interventions, such as social distancing. An example of surveillance testing is a plan developed by a state public health department to randomly select and sample a percentage of all individuals in a city on a rolling basis to assess local infection rates and trends.[29]

TESTING RECOMMENDATION

The CDC and DC Health recommend prioritizing testing for individuals with symptoms of COVID-19.

DC Health does not recommend universal testing of all students and staff as a prerequisite to school attendance. Screening testing might be an effective tool at reducing transmission in schools when

[27] Centers for Disease Control and Prevention (CDC) (Oct. 23, 2020). *Interim guidance for use of pooling procedures in SARS-CoV-2 diagnostic, screening, and surveillance testing*. Centers for Disease Control and Prevention. https://www.cdc.gov/coronavirus/2019-ncov/lab/pooling-procedures.html.

[28] Ibid.

[29] Ibid.

combined with prevention measures, such as face mask use and physical distancing. The benefits of school-based testing should be weighed against the costs, inconvenience, and feasibility of such programs to both schools and families. Students should not be required to participate in screening testing in order to attend school. The following should be considered as part of screening testing:

- Screening testing may be particularly useful when DC is experiencing moderate to substantial community spread (Phase 2).
- Screening testing could provide added protection for schools that use less than 6 feet of physical distancing between students in classrooms.
- Screening testing for teachers should be considered regardless of community transmission.
    - Consider offering weekly screening testing for asymptomatic teachers and school staff who are not fully vaccinated.
- Screening testing for students should be considered when DC is experiencing moderate to substantial community spread (Phase 0/1, 2).
    - Consider testing a random sample of at least 10 percent of asymptomatic students a week. Random selection could also occur by screening selected cohorts on a weekly basis, for example.
- If a prioritization strategy is needed due to supplies or feasibility, schools should consider prioritizing teachers. Amongst students, prioritization of high school students, then middle school students, and then elementary school students is a recommended strategy, as higher infection rates occur in older students.
- Screening testing can also be targeted to high-risk situations, such as unvaccinated staff who may oversee multiple cohorts of students.
- Pooled testing may be considered as an option; however, this method is more appropriate when cases are very low. If a pooled sample tests positive, all affected students and staff and their close contacts must not attend school until confirmatory results return.
- DC Health does not recommend that fully vaccinated individuals who do not have any symptoms participate in routine screening testing.

Per DC Health, screening testing for sports may also facilitate safer participation. Strategies include:

- Testing for athletes, coaches, and trainers;
- Universal screening before games or athletic events;
- Weekly testing for low- and moderate-contact sports, or those that can be played outdoors or indoors with masks; and
- Twice weekly testing for high-contact sports during Phase 2 and 3, or twice weekly testing during Phase 0/1.

Public and public charter schools may contact the Office of the Deputy Mayor for Education and OSSE at EdSupport@dc.gov to learn about testing programs that are available in public and public charter schools.

Per DC Health, schools that are participating in a formal screening or surveillance testing program as part of the broader policy of an umbrella organization should defer to the testing policy of their umbrella organization. Schools wishing to implement a formal screening or surveillance program in consultation with their health services provider should develop a testing plan and share that plan with the Deputy Mayor for Education and OSSE teams at EdSupport@dc.gov.

TESTING AVAILABILITY

DC Health is implementing testing for symptomatic and asymptomatic students in its school health suites for schools that participate in the School Health Services Program. More information is available from DC Health at SHS.Program@dc.gov.

Schools wishing to learn more about options for testing for staff or for students in schools that do not participate in the School Health Services Program may inquire at EdSupport@dc.gov.

Additionally, testing is available through one's healthcare provider, home test kits available from DC Health, and the city's public testing sites. More information is available at coronavirus.dc.gov/testing. At present, anyone who is a District of Columbia resident, age 3 or older, or who works at a school in the District of Columbia who presents for a test, symptomatic or not, can get a free test at one of the city's testing sites.

- You do not need a doctor's note for any of the walk-in sites.
- Testing sites and additional information can be found at coronavirus.dc.gov/testing.