

## Frequently Asked Questions (FAQ) for Schools

Additional Guidance as of **June 7, 2021**

(subject to change based on new information and updates to existing CDC guidance)

### Management of Ill Students and Staff

#### **1. What actions should be taken by students/staff sent home with COVID-like symptoms? (Updated 10/27/2020)**

- All students and staff sent home with COVID-like symptoms should be diagnostically tested. Students and staff should remain home from school until they receive the test results. Students and staff who are confirmed or probable cases of COVID-19 must complete 10 calendar days of isolation from the date of first symptom onset **and** be fever-free for 24 hours without use of fever-reducing medications **and** other symptoms have improved before returning to school. Individuals who have been cleared by the LHD for release from isolation may return to school even if other household members are in isolation or quarantine in the home.
- Students and staff returning to school after experiencing COVID-like symptoms but being diagnosed with a non-COVID illness must meet the criteria for returning to school for the illness with which they have been diagnosed. At a minimum, the individual must be fever-free for 24 hours without the use of fever-reducing medications **and** have had no diarrhea or vomiting in the previous 24 hours. Other diseases have specific criteria for when a student or staff member can [return to school](#)<sup>1</sup>. Follow school health policies and communicable disease guidance for those illnesses. A healthcare provider's note documenting the alternative diagnosis, or a negative COVID-19 test result should accompany a student or staff member returning to school with an alternative diagnosis after experiencing COVID-like symptoms. Schools and districts should assist families in locating free or reduced-cost medical clinics for assistance where needed.
- Students and staff with COVID-like symptoms who do not get tested for COVID-19 and who do not provide a healthcare provider's note documenting an alternative diagnosis, must complete 10 calendar days of isolation from the date of first symptom onset **and** be fever-free for 24 hours without use of fever-reducing medications **and** other symptoms have improved before returning to school.
- Medical evaluation and COVID-19 diagnostic testing are strongly recommended for all persons with COVID-like symptoms.

#### **2. If a student is sent home sick with suspected COVID-19 symptoms (e.g., cough, fever, diarrhea, shortness of breath, etc.), must all their siblings/household members be sent home as well and quarantined? (Updated 6/7/2021)**

Yes. If one household member is being evaluated for COVID-19, the rest of the household must be quarantined until an alternative diagnosis is made or negative result received, **unless the household member contact is [fully vaccinated](#) and asymptomatic or has positive SARS-CoV-2 antibodies as described in question #4.** Fully vaccinated persons are not required to quarantine but should self-monitor for symptoms for 14 days after their last exposure to the case during the case's infectious

**period.** If the sick student is classified as a confirmed case (i.e., tests positive for COVID-19) or a probable case (i.e., has COVID-like symptoms and is epidemiologically linked<sup>2</sup> to a known case), the local health department (LHD) conducting contact tracing will **place unvaccinated or partially vaccinated household contacts or those who are less than two weeks since completing the vaccination series, in quarantine.**

**For persons being placed in quarantine, IDPH, along with CDC, continues to recommend a 14-day quarantine. However, based on local circumstances and resources, CDC has provided options to reduce quarantine that local health departments (LHDs) may implement using symptom monitoring and diagnostic testing. Reduced quarantine options that may be considered include:**

- **Option 1:** Quarantine period is for 10 calendar days after the close contact's last exposure to the COVID-19 case. Date of last exposure is considered Day 0.
  - The individual may end quarantine after Day 10 if no symptoms of COVID-19 developed during daily monitoring.
  - SARS-CoV-2 PCR testing is recommended and may be required by the local health department.
  - The individual can maintain physical distancing and masking at all times when returning to school; **for classrooms where masking is strictly adhered to, physical distance of 3 to 6 feet is acceptable for return.**
- **Option 2 (should not be applied to non-adult students/children):** Quarantine period is for 7 calendar days after the last exposure if:
  - No symptoms developed during daily monitoring AND
  - The individual has a negative SARS-CoV-2 diagnostic test (PCR) that was collected within 48 hours of exposure Day 7 (starting on Day 6 or after).
    - The individual is responsible for obtaining a copy of the negative results for documentation purposes.
  - The individual can maintain physical distancing and masking at all times when returning to school; **for classrooms where masking is strictly adhered to, physical distance of 3 to 6 feet is acceptable for return.**

The 7-day early quarantine release option is not recommended for children. **Local health authorities will determine which options are allowable in their jurisdiction.**

**Regardless of when an individual ends quarantine, daily symptom monitoring should continue through calendar day 14 after the exposure.** Individuals should continue to adhere to recommended mitigation strategies, including proper and consistent mask use, physical distancing, hand hygiene, cough hygiene, environmental cleaning and disinfection, avoiding crowds and sick people, and ensuring adequate indoor ventilation. **If any symptoms develop during or after ending quarantine, the individual should immediately self-isolate** and contact their local health department or healthcare provider to report their symptoms.

The health department can provide guidance on how to safely quarantine and isolate within the household.

### **3. Do vaccinated staff have to quarantine after an exposure to a case? (3/16/2021)**

Vaccinated staff may not need to quarantine if they meet all the following criteria:

- Are fully vaccinated (i.e., ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine).

- Have remained **asymptomatic** since the current COVID-19 exposure.

Note that **fully vaccinated** is defined as  $\geq 2$  weeks following receipt of the second dose in a 2-dose series, or  $\geq 2$  weeks following receipt of one dose of a single-dose vaccine. If a staff member has received both doses, but the exposure to a COVID-19 case occurs before it has been a full two weeks after completing the vaccine series, the staff member should follow quarantine recommendations for unvaccinated persons. The staff member should continue to monitor for symptoms for 14 days after the exposure, **regardless of vaccination status**, and **if any symptoms develop, they should immediately self-isolate** and contact their local health department or healthcare provider to report their symptoms.

#### 4. Does an individual with positive SARS-CoV-2 antibody testing have to quarantine (6/7/2021)?

Antibody testing **should not be promoted as a way to avoid quarantine**. The robustness and durability of immunity following natural infection remain unknown. LHD's should make decisions on quarantine and isolation on a case-by-case basis using CDC/IDPH guidance and antibody testing should be used sparingly. For example, antibody testing may be used to exempt someone from quarantine when the individual is documented as a probable case (i.e., has COVID-like symptoms and is epidemiologically linked<sup>2</sup> to a known case) and they never received a diagnostic test. Per [CDC guidance on serologic antibody testing](#), unvaccinated persons who have tested antibody positive (with an FDA-authorized test) within 3 months before or immediately following an exposure to someone with suspected or confirmed COVID-19 and who have remained asymptomatic since the current COVID-19 exposure do not need to quarantine, provided there is limited or no contact with persons at high risk for severe COVID-19 illness. This includes [older adults and persons with certain medical conditions](#).

Serologic testing does not replace virologic testing and should not be used to establish the presence or absence of acute SARS-CoV-2 infection, nor should it be used to determine immunity after vaccination or to determine if vaccination is needed in an unvaccinated person.

#### 5. How many symptoms does a person need to have to be considered a suspect COVID-19 case? (Updated 6/7/2021)

Students and staff exhibiting one or more COVID-like symptoms are considered suspect cases and should be immediately isolated and evaluated. Schools should evaluate each symptomatic student/staff to determine if this symptom is new or if it is part of an existing condition for this student/staff.

The [IDPH Decision Tree](#) and [CDC Screening in K-12](#) webpage both were recently updated to limit the symptoms for which students should be screened for suspect COVID-19 infection. Many symptoms of COVID-19 are also symptoms of common illnesses like seasonal allergies and colds. Students with chronic conditions like asthma or allergies might have symptoms such as nasal congestion or cough without an infectious illness. To balance these considerations and to prevent potentially excluding students repeatedly, the list of symptoms has been limited to those most likely to be part of an infectious syndrome. However, if a student/staff has a COVID-19 symptom not listed on the Decision Tree, but the school health staff has an increased concern due to community spread or known close contact (as shown in Box A and Box B of the Decision Tree), the school health staff should exclude the individual and require testing or an alternative diagnosis for return.

**6. Our current school policy recommends sending children home with a temperature of 100.0°F or greater. The ISBE and CDC guidance both say 100.4°F or greater. Which should we use? (Updated 10/27/2020)**

For consistency with CDC and Illinois Joint Guidance for Schools, it is recommended that schools use 100.4°F or greater as the threshold for fever.

**7. If the sick person has a known condition causing the symptoms, e.g., allergies, migraine, etc., can this be taken into consideration? (Updated 10/27/2020)**

Every symptomatic person should be evaluated by their healthcare provider on a case-by-case basis and decisions to test for COVID-19 should be based on their personal health history. Each episode of new symptom onset should be evaluated. Diagnostic testing is strongly encouraged whenever an individual experiences COVID-like symptoms; it is possible to have COVID-19 and other health conditions at the same time. Early diagnosis can prevent further transmission. Individuals who have undergone testing should remain home away from others while waiting for COVID-19 test results.

**8. What are the recommendations for someone who has previously tested positive for COVID-19? (Updated 10/27/2020)**

For those who have had prior diagnoses of COVID-19 confirmed by viral testing within 3 months, isolation and quarantine may not be needed. The table below describes various scenarios that may occur. Schools are encouraged to discuss these situations with their LHDs for clear guidance.

<b>Recommended Actions for Previous COVID-Positive Individuals</b>	<b>Less than 90 days (3 months) from last Positive Test</b>	<b>Greater than 90 days (3 months) from last Positive Test</b>
Refer for clinical evaluation if COVID-like symptoms are present?	YES	YES
Repeat COVID-19 test if COVID-like symptoms are present?	NOT Recommended. Healthcare Provider may decide to test based on clinical assessment.	YES
Exclude from school if COVID-like symptoms are present?	Refer to <b>Column C</b> in Exclusion Guidance Decision Tree.	If COVID test <b>positive</b> : Refer to <b>Column A</b> in Exclusion Guidance Decision Tree. If COVID test <b>negative</b> : Refer to <b>Column B</b> in Exclusion Guidance Decision Tree.
Place in quarantine if named as a close contact to a known case of COVID-19?	NO	YES

**9. If after completing 10 days in isolation a “probable” COVID-19 case (based on known exposure, symptoms, and positive serology) has a subsequent exposure to a confirmed case of COVID-19, does this person need to be placed in quarantine? (Updated 6/7/2021)**

CDC guidance now states that unvaccinated individuals with positive SARS-CoV-2 antibody testing that is within 3 months prior to or immediately after an exposure to someone with suspected or confirmed COVID-19 and who have remained asymptomatic since the current COVID-19 exposure

do not need to quarantine, provided there is limited or no contact with persons at high risk for severe COVID-19 illness, including older adults and persons with certain medical conditions. So, if a probable case is able to provide positive results from antibody testing in the timeframe described above, the LHD may consider releasing the staff/student from quarantine.

Serologic testing is not diagnostic and should not be used to diagnose acute SARS-CoV-2 infection or determine immunity from vaccination or to assess the need for vaccination in unvaccinated persons.

## **Contacts to Cases**

### **10. What is contact tracing?**

Contact tracing is used by health departments to prevent the spread of infectious diseases. In general, contact tracing involves identifying people who have a confirmed or probable case of COVID-19 (cases) and people who they came in contact with (close contacts) and working with them to interrupt disease spread. This includes asking people with COVID-19 to isolate and their contacts to quarantine at home voluntarily.

### **11. Who is a close contact? (Updated 6/7/2021)**

A close contact is anyone (with or without a face covering) who was within 6 feet of a confirmed case of COVID-19 (with or without a face covering), for a cumulative total of 15 minutes or more over a 24-hour period during the infectious period. **Per the Interim Guidance on Testing in Community Setting and Schools for modified quarantine options for schools with screening testing programs and where mask adherence was strictly adhered to, classroom close contacts requiring quarantine may be assessed as persons within 3 feet of a case for 15 cumulative minutes within a 24-hour time frame.** Repeated exposures result in an increased amount of time of exposure; the longer a person is exposed to an infected person, the higher the risk of exposure/transmission. Higher risk exposures, including unmasked lunchroom companions, high and medium risk contact sports teammates and opponents, and music class participants may be assessed as close contacts for contact times less than 15 minutes, as determined by the LHD. The infectious period of a confirmed case begins 2 calendar days before the onset of symptoms (for a symptomatic person) or 2 calendar days before the positive sample was obtained (for an asymptomatic person). If the case was symptomatic (e.g., coughing, sneezing), persons with briefer periods of exposure may also be considered close contacts. Close contacts to a confirmed case of COVID-19 are required to remain in quarantine at home for 7, 10 or 14 calendar days starting from the last day of contact with the confirmed case. (See question #2)

### **12. Who will do contact tracing?**

Contact tracing will be performed by the Local Health Department (LHD), sometimes in partnership with IDPH or a community-based organization. However, schools can assist the LHD by identifying all close contacts to a confirmed case. Both schools and any other third parties are required, pursuant to the State's regulations, to cooperate in the LHD's disease investigation and contact tracing initiatives. Cooperation with contact tracing and disease investigation by parents/guardians and other individuals can help ensure infection control measures are being maximized. Documentation

of assigned seats and taking photos of assembled classes can be useful in helping schools determine who was within 6 feet of a given case.

Schools must be aware of records and confidentiality laws pertaining to school student records, including exceptions for release of information in the event of an emergency and requirements to notify parents and create a record of emergency releases of information. (105 ILCS 10/6(a)(7); 23 Ill. Admin. Code 375.60).

**13. Is contact tracing only performed when a positive test is received? (Updated 10/27/2020)**

Contact tracing is performed for a confirmed case (positive PCR test) or a probable case (positive antigen test OR person with clinically compatible COVID-like symptoms and epidemiologically linked<sup>2</sup> via known exposure to a confirmed case.

**14. If a confirmed or probable COVID-19 case is identified in a classroom, or on a school bus, who will be considered close contacts that need to be quarantined? Will this include the entire classroom or all the students on the bus? (Updated 10/27/2020)**

Exposure in a classroom should be limited to everyone with whom the confirmed or probable COVID case had close contact, within 6 feet, for a cumulative total of at least 15 minutes throughout the course of a 24-hour period. Exposure on a bus must include everyone who sat within 6 feet of the confirmed or probable COVID case for 15 minutes or longer. A possible approach to identifying close contacts on a bus would be to include persons who sat 3 rows in front and 3 rows behind the confirmed or probable COVID case.

**15. If the close contact and the COVID case were both wearing their cloth face coverings when the exposure occurred, is the close contact still required to be quarantined?**

Yes. While there is strong evidence that face coverings significantly reduce the risk of infection, the likelihood for transmission cannot be ruled out.

**16. Is a healthcare provider's note required to return to school after a 'close contact' to a case completes the required time frame in quarantine? (Updated 1/4/2021)**

Persons who remain in quarantine for 10 or 14 calendar days and who remain asymptomatic throughout quarantine do not need a healthcare provider's note to return to school. Documentation to return to school includes a Release from Quarantine letter (if received from their LHD) provided by the parent/guardian OR notification via phone, secure email, or fax from the LHD to the school, OR via another process implemented by the LHD.

Individuals who observe the 7-calendar-day quarantine period must remain asymptomatic **AND** have a negative SARS-CoV-2 PCR test (collected with 48 hours of Day 7) to return to work at school. It is the responsibility of the individual to provide the documentation of the negative SARS-CoV-2 result, in addition to the quarantine release letter as described above. School nurses should verify the diagnostic testing specimen was collected within 48 hours of exposure Day 7. To do this, school nurses will need to know the close contact's last exposure date to the COVID-19 case.

**17. What tests are acceptable for release from quarantine (after Day 7) for staff only? (Updated 6/7/2021)**

Antigen testing can be used to release adult staff from quarantine when one of the early quarantine-release options is implemented. CDC guidance states that a negative result from a SARS-CoV-2 diagnostic test is acceptable for reducing quarantine, if the person has also remained asymptomatic. When readily available and turn-around time is good, the gold-standard nucleic amplification testing, including RT-PCR, is preferred. For students using the 10-day release, IDPH recommends a negative RT-PCR as well. At-home antigen tests are not recommended for meeting criteria to reduce quarantine at this time; only testing administered by either school health staff or by laboratory personnel is acceptable.

**18. What is the definition of an outbreak in Pre-K-12 schools? (Updated 1/4/2021)**

Five COVID-19 infections (laboratory-positive by PCR or antigen testing) occurring within 14 calendar days of each other in individuals meet the case definition for an outbreak in a Pre-K-12 school. The cases need to be epidemiologically linked<sup>2</sup> by known exposure with respect to place (same classroom) and time (within 14 calendar days). This would prompt an investigation by the LHD that may result in recommendations for testing and quarantining of students/staff in the affected classroom.

For childcare or daycare settings, two or more individuals who are laboratory-positive for COVID-19 (by PCR or antigen testing) is considered an outbreak.

This outbreak definition for schools was implemented 10/27/2020 and will be used to classify all outbreaks going forward from that date. Previous school outbreaks (classified with 2 or more cases) will not be changed and will still count as outbreaks. The childcare/daycare outbreak definition has not changed.

**19. If a student or staff member is identified as a close contact to a person with COVID-19 and is instructed to quarantine, are their household members and close contacts also required to be in quarantine? (Updated 12/2/2020)**

No. Contacts of a person who is a close contact to a COVID-19 case (i.e., contacts to contacts) do not need to self-quarantine unless they develop symptoms or if the person identified as the close contact develops COVID-19. They should, however, monitor themselves closely for symptoms of COVID-19 and if they become symptomatic, self-isolate and seek medical evaluation/testing.

**20. Why are reduced quarantine periods now offered as acceptable alternatives to the recommended 14-calendar day quarantine? (1/4/2021)**

Quarantine is intended to reduce the risk that infected persons might unknowingly transmit infection to others and helps ensure that persons who become symptomatic or test positive can be promptly referred for medical evaluation and care. However, because the length of quarantine may impose personal and/or financial burdens and be a disincentive to naming contacts or responding to contact tracing efforts, reducing the length of quarantine may increase community compliance with observing quarantine and contact tracing.

The recommendation for a 14-day quarantine was based on the upper bounds of the COVID-19 incubation period. With a 10-day quarantine strategy, residual post-quarantine transmission risk is estimated to be about 1% with an upper limit of about 10%. With a 7-day quarantine and required



negative diagnostic SARS-CoV-2 test strategy, the residual post-quarantine transmission risk is estimated to be about 5% with an upper limit of about 12%.

Shortening quarantine may increase willingness to adhere to public health recommendations but will require evaluation of compliance with quarantine and contact tracing activities and monitoring for evidence of post-quarantine transmission. School nurses are important partners in this evaluation and should notify local health departments of potential post-quarantine transmission cases and clusters.

**21. Are schools required to use the 14-day quarantine? Are schools considered congregate settings? (1/4/2021)**

Local public health authorities determine and establish the quarantine options for their jurisdictions, so schools will need to consult with their local health departments. Local public health authorities and departments may choose not to utilize shortened quarantine options in their jurisdictions due to high levels of community transmission.

Due to the risk of severe illness and congregate transmission, IDPH does not recommend application of the two shortened quarantine options in congregate care settings with vulnerable populations (e.g., long term care (LTC), homeless shelters, and prisons). Most schools are not considered congregate living settings. If you are unsure, contact your local health department for guidance.

**Special Situations/Other Groups**

**22. Can the school nurse administer nebulizer treatments on campus?**

Where possible, nebulizer treatments should be scheduled to be administered at home or the student may switch to metered dose inhalers with spacers for use at school. Nebulizer treatments, if required to be administered at school, should be done in a separate room with only the school nurse and student present. Nebulizer treatments should be administered to only one student at a time. If a window or fan is available, open the window and vent the fan to blow out of the window. The person administering the treatment should wear personal protective equipment (PPE) including a fit-tested N95/KN95 respirator, a face shield or goggles, gown, and gloves. Hand hygiene (washing) should be performed before donning (putting on) and after doffing (removing) PPE. Upon completing the nebulizer treatment, the student should perform hand hygiene. The room should be left vacant for a period of time (suggested minimum of 2 hours) then thoroughly cleaned and disinfected. Consult with individual student health care providers, if applicable, and Individualized Education Program (teams to determine the best modality to meet students' needs on an individualized basis. Appropriate consents must be obtained for communication with outside providers. Review IEPs, 504 Plans, asthma action plans, or Individualized Health Plans to determine if these plans will need to be amended or modified.

**23. Playing of some music instruments and singing are recognized as ways COVID-19 can be spread more easily by respiratory droplets. How can we prevent transmission in band or music classes? (Updated 1/4/2021)**

All persons playing instruments in orchestra, band, or general music settings, singing in choir or other lessons, dancing, participating in color guard, or teaching should wear a washable or



disposable, multi-layered face covering or mask. Students who play wind instruments are able to use face coverings with a slit. Face coverings may only be removed while outdoors when physical distance is maintained. Whenever possible, hold music classes outside. When possible, music classes held indoors should occur in well-ventilated spaces and if possible, with windows open. A minimum distance between singers and/or instrumentalists of 6 feet side-to-side should be maintained. For trombones, a minimum distance of 9 feet front-to-back is recommended. Ensure students (and teachers) are physically distanced from each other by at least 6 feet and consider increasing the amount of physical distancing more than 6 feet if space allows. Have students in one line or **stagger** spacing to ensure maximum distancing. Students should not face each other. Instruments where air is blown into or through should be turned so that expelled air does not go towards others. Instrument covers consisting of a minimum of two layers of dense fabric should be used over instrument bells to prevent spread. For additional guidance on music classes, please see IDPH Interim COVID-19 Music Guidance.

**24. Occasionally, students share music, equipment, and even instruments. How do we manage these situations?**

Avoid sharing instruments. If instruments must be shared (e.g., drums), they should be cleaned and disinfected between students<sup>3</sup>. Music reeds and mouthpieces should **not** be shared. Note that some instrument surfaces may be damaged by cleaning and disinfecting products, so contact your instrument dealer for guidance on disinfection, and follow the manufacturer's instructions for cleaning. Discourage the sharing of music stands so that students do not inadvertently move closer to each other to see the music.

**25. If an athlete is diagnosed with COVID-19, is it up to the school to notify all other teams that the athlete has been in contact with?**

Yes, the school should make generic notifications to other schools and teams with which the confirmed or probable COVID athlete may have had contact without identifying the person's name. Provide minimal information to protect confidentiality, but enough for the school to respond as needed. The LHD can assist in making this notification.

**26. What is the role of the Local Health Department in a situation involving an athlete diagnosed with COVID-19? (Updated 1/4/2021)**

The LHD will conduct contact tracing to identify close contacts (including household, physical, and sport-related) to the case and place them in quarantine for the recommended period of time.

**Testing**

**27. What is the average amount of time after receiving a COVID test that results will be received?**

Turnaround time (TAT) for laboratory test results is dependent on laboratory capacity. Typically, the TAT for test results from the state lab is 2-3 calendar days. The TAT can increase when the demand for testing is high. Private reference labs may be able to offer a shorter TAT and should be considered as an option for testing.

**28. Can the school be notified of a confirmed or probable case as quickly as possible?**

Schools should ask parents/guardians to notify the school as quickly as possible of any confirmed or probable COVID-19 cases. It is important that schools communicate this expectation to parents/guardians early and often. The local health department (LHD) will also receive a report of a confirmed or probable case from either a lab or provider. However, the report does not necessarily include school information (unless the school was the test submitter). This means that the LHD must obtain this information by interviewing the case/parent/legal guardian. The LHD will notify the school as soon as they have acquired the school information. Schools should identify a point of contact for LHDs, including someone who can be reached after hours.

**29. If a student or staff member presents a note or negative COVID-19 test result, for how many days is that test result valid?**

A negative polymerase chain reaction (PCR) test is valid only for the day on which it was reported. It denotes that on the day that the sample was collected, the individual being tested did not have any detectable virus in their system. Because the incubation period (time from exposure to infection) for COVID-19 is 2-14 calendar days, a person with a negative test may still develop infection at some point during the incubation period.

**30. When is a confirmatory PCR test required for possible cases in the school setting? (6/7/2021)**

As shown in the [CDC's testing algorithm](#) (see Figure 1) and referenced in [IDPH's Rapid Point-of-Care Testing for COVID-19 in Community Settings and Schools](#), confirmatory testing for antigen and rapid nucleic acid amplification tests (NAATs) is sometimes required when the results are different than what is expected (e.g., positive result in an asymptomatic person with no known exposure). In these circumstances, CDC recommends a lab-based (non-rapid) NAAT (such as a PCR) from a nasal specimen.

In contrast, for staff/students being excluded due to COVID-like symptoms, if the staff/student is a close contact to a confirmed case, the school is experiencing an outbreak, or the LHD is requiring validation due to community transmission levels, documentation of a negative NAAT (e.g., RT-PCR) COVID-19 test result is needed. The SHIELD Illinois saliva test is a RT-PCR and can be used in these situations. If the student/staff does not have a known close contact, the school is not in outbreak, or the LHD is not requiring confirmatory testing due to the level of community transmission, a negative RT-PCR, rapid molecular (rapid PCR) or negative antigen test is acceptable. (With low pre-test probability, NAAT testing (e.g., PCR) following a negative antigen test is not required.)

**Personal Protective Equipment (PPE)**

**31. What PPE is required to work in or attend school? (Updated 10/27/2020)**

All persons on school grounds including students, teachers, school nurses, administrative and secretarial staff, food service personnel, custodial staff, public safety personnel, etc., must wear a face covering at all times when in school or in transit to and from school via group conveyance (i.e., school buses), unless a specific exemption applies. The face covering should have two or more layers to stop the spread of COVID-19, and should be worn over the nose and mouth, secured under the chin, and should fit snugly against the sides of the face without gaps.

Masks intended for healthcare workers, such as N95 respirators, should not be worn. There are also masks available with exhalation valves or vents. These are not recommended for source control of COVID-19 and should NOT be worn.

See additional guidance as follows regarding safe and effective use of face coverings.

### **32. What is the primary purpose of a face covering? (Updated 10/27/2020)**

Cloth face coverings 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 cloth face covering coughs, sneezes, talks, or raises their voice. This is called source control. The primary purpose of a face covering is to prevent the wearer from potentially exposing or infecting others. To be effective, face coverings must be worn properly and must completely cover both the nose and mouth.

### **33. How should cloth face coverings be cleaned and stored?**

Personal cloth face coverings should be taken home, laundered daily, dried in a dryer, and reused. Personal cloth face coverings should be stored between uses in a clean sealable paper bag or breathable container.

### **34. When should a face covering be changed?**

Face coverings must be changed immediately if soiled, wet, or torn.

### **35. Can face coverings be removed at certain times? (Updated 6/7/2021)**

Yes – face coverings may be temporarily removed at school:

- When eating
- When playing a musical instrument outdoors with at least 6 feet physical distancing
- If using a face shield when other methods of protection are not available or appropriate (<https://www.isbe.net/Documents/IDPH-Update-Appropriate-Use-Face-Shields.pdf>)
- While children are napping with close monitoring to ensure no child leaves their designated napping area without putting their face covering back on
- For staff, when alone in classrooms or offices with the door closed
- For fully vaccinated staff when meeting with other fully vaccinated staff outside of settings where unvaccinated persons are present
- **For staff and students when they are outdoors. However, particularly in areas of substantial to high transmission per CDC COVID Data Tracker or IDPH's COVID-19 County & School Metrics, staff and students who are not fully vaccinated should wear a mask in crowded outdoor settings or during activities that involve sustained close contact with other people who are not fully vaccinated.**

Strict adherence to physical distancing should be maintained when face coverings are removed in limited situations.

### **36. What if a student or staff member is unable to tolerate wearing a face covering? (Updated 9/9/20)**

Individuals who have a condition or medical contraindication (e.g., difficulty breathing) that prevents them from wearing a face covering are required to provide documentation from the individual's healthcare provider. These persons may wear a face shield in lieu of a face covering; however, physical distancing must be strictly enforced. Measures to reduce risk of exposure for these persons should be implemented where possible.

### **37. What practices should be followed for children during naptime? (Updated 9/9/20)**

Ensure that children's naptime mats and cots are spaced at least 6 feet apart as much as possible. Consider placing children head to toe to further reduce the potential for viral spread. Use bedding (sheets, pillows, blankets, sleeping bags) that can be washed weekly. Keep each child's bedding separate and stored in individually labeled bins, cubbies, or bags. Label cots and mats individually for each child. Face coverings can be removed while children are napping with close monitoring to ensure that no child leaves their designated napping area without putting on their masks. Children should be instructed to not talk or sing during nap time. Where possible, provide good ventilation where the children are napping, opening windows when feasible and incorporating fresh air into the ventilation system.

### **38. What PPE is required by school nurses who are assessing a student or staff member reporting COVID-like symptoms? (Updated 10/27/2020)**

If the nurse is screening a sick individual, it will be safest for them to be wearing a fit-tested N95 mask, eye protection with face shield or goggles, gown, and gloves. When performing clinical evaluation of a sick individual, school nurses will use enhanced droplet and contact transmission-based precautions. Staff performing this evaluation should use appropriate personal protective equipment (PPE) including:

- Fit-tested N95 respirator
- Eye protection with face shield or goggles
- Gown
- Gloves

Any staff member who may be involved in the assessment or clinical evaluation of a student or staff member with COVID-like symptoms should be trained on the type of PPE required and how to don (put on) and doff (remove) it correctly and safely.

Respirators such as N95s must be used as part of a written respiratory protection program.<sup>4</sup> OSHA requires that N95 masks be fit tested prior to use. This is an important step to ensure a tight fit for the mask to be effective in providing protection. If a fit-tested N95 respirator is not available, the next safest levels of respiratory protection include, in the following order: a non-fit-tested N95 respirator, a KN95 respirator on the FDA-approved list<sup>5</sup>, or a surgical mask.

### **39. If a nurse or staff member was wearing full PPE as recommended and was in the same room as a student or staff member later determined to be a probable or confirmed COVID-19 case, is that nurse or staff member required to quarantine? (Updated 10/27/2020)**

If wearing the recommended PPE appropriately, the nurse evaluating the student or staff member who is later determined to be a probable or confirmed COVID-19 case would not be recommended for quarantine as a close contact. The nurse should continue to follow all recommended infection

prevention and control practices, including wearing a facemask for source control while at work, actively monitoring themselves for fever or COVID-19 symptoms prior to work and while working, and staying home if ill. See <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>.

#### **40. Can a face shield be worn instead of a face covering?**

Because respiratory droplets may be expelled from the sides and bottom of face shields, they do not provide adequate 'source control' and should only be used as a substitute for face coverings in the following limited circumstances:

- Individuals who are under the age of 2.
- Individuals who are unconscious, incapacitated, or otherwise unable to remove the cover without assistance.
- Students who provide a health care provider's note as documentation that they have a medical contraindication (a condition that makes masking absolutely inadvisable) to wearing a face covering.
- Teachers needing to show facial expressions where it is important for students to see how a teacher pronounces words (e.g., English learners, early childhood, foreign language, etc.). However, teachers will be required to resume wearing face coverings as soon as possible. Preferred alternatives to teachers wearing face shields include clear face coverings or video instruction. There must be strict adherence to physical distancing when a face shield is utilized.

#### **41. Who has the credentials to be able to provide a medical note or perform a routine health check-up? (Updated 9/9/20)**

IDPH recommends that a healthcare provider licensed to practice medicine in all branches of medicine, as defined in [105 ILCS 5/27-8.1](#), be referred to for providing medical notes and performing routine health check-ups.

#### **42. How should schools handle students with IEPs or 504 plans who cannot tolerate a face covering or a face shield?**

Students with an Individualized Education Program (IEP) or 504 Plan who are unable to wear a face covering or face shield due to a medical contraindication may not be denied access to an in-person education if the school is offering in-person education to other students. Staff working with students who are unable to wear a face covering or shield due to a medical contraindication should wear approved and appropriate PPE based on job specific duties and risks and maintain physical distancing as much as possible. Other students should also remain physically distant from students who are unable to wear a face covering or face shield due to a medical contraindication. Schools should consult with their local public health department regarding appropriate PPE for these situations.

#### **43. Can neck warmers be used as a substitute for cloth face coverings? (Updated 10/27/2020)**

It is not known if athletic face coverings/neck warmers provide any benefit as source control to protect others from the spray of respiratory particles. CDC does **not** recommend use of athletic face coverings (e.g., 'gaitors'/neck warmers as a substitute for cloth face coverings.

#### 44. Can you provide recommendation on cleaning? (Updated 10/27/2020)

Schools should follow CDC's [guidance for cleaning and disinfecting public spaces, workplaces, businesses, schools and homes](#). **Cleaning and disinfection products should not be used by children or near children**, and staff should ensure that there is adequate ventilation when using these products to prevent children or themselves from inhaling toxic fumes.

#### 45. What kind of PPE is required for staff who clean areas used by a suspected or known COVID case? (Updated 8/20/20)

If a janitor is cleaning an area used by a suspected or known COVID case, it will be safest for them to be wearing a fit-tested N95 mask, eye protection with face shield or goggles, gown, and gloves.

#### 46. Can clear face coverings be utilized? (Updated 9/9/20)

While [cloth face coverings](#) are strongly encouraged to reduce the spread of COVID-19, CDC recognizes there are specific instances when wearing a cloth face covering may not be feasible. In these instances, parents, guardians, caregivers, teachers, staff, and school administrators should consider [adaptations and alternatives](#) whenever possible. They may need to consult with healthcare providers for advice about wearing cloth face coverings.

People who are deaf or hard of hearing—or those who care for or interact with a person who is hearing impaired—may be unable to wear cloth face coverings if they rely on lipreading to communicate. This may be particularly relevant for faculty or staff teaching or working with students who may be deaf or hard of hearing. In this situation, consider using a **clear face covering** that covers the nose and wraps securely around the face. If a [clear face covering](#) isn't available, consider whether faculty and staff can use written communication (including closed captioning) and decrease background noise to improve communication while wearing a cloth face covering that blocks your lips.

In addition to those who interact with people who are deaf or hard of hearing, the following groups of teachers and staff may also consider using clear face coverings:

- Teachers of young students (e.g., teaching young students to read).
- Teachers of students who are English language learners.
- Teachers of students with disabilities.

### School Closure

#### 47. If there is a confirmed or probable case of COVID-19 within a school, what are the recommendations for school closure? (Updated 6/1/2020)

Decisions for temporary closure of a school will be made by school leaders in consultation with the LHD during its investigation of a case or cluster of cases. If the LHD determines that there is a risk to the school community, the school may be closed temporarily for cleaning and disinfection. This initial short-term dismissal allows time for the local health officials to gain a better understanding of the COVID-19 situation impacting the school. This also allows the local health officials to help the

school determine appropriate next steps, including whether an extended dismissal duration is needed to stop or slow further spread of COVID-19.

Please reference the IDPH [Adaptive Pause and Metrics: Interim School Guidance for Local Health Departments](#) (dated March 16, 2021) for additional guidance to inform decisions about implementing school-based strategies (e.g., pivot to remote learning, event or extracurricular cancellations, other physical distancing measures). As stated above, these decisions should be made locally, in collaboration with local health officials, who can help determine the level of transmission in the community, and in conformity with ISBE/IDPH Joint Guidance. This IDPH guidance is consistent with the September 15, 2020 guidance released from CDC on [Indicators for Dynamic School Decision-Making](#). The CDC's guidance also encourages schools to self-assess implementation of key mitigation strategies as part of the decision-making process.

**48. Are there alternative strategies to school closure that may be considered or employed? (Updated 10/27/2020)**

In consultation with the Local Health Department, alternative strategies, less drastic than closure, a school may implement might include:

- Quarantining the affected classroom where physical distancing is challenging (e.g., early childhood).
- Suspending affected classes or closing playgrounds.
- Canceling non-essential activities and meetings.
- Keeping students in constant class groups or classrooms and moving teachers routinely between classes.
- Increasing spacing between students in classes.
- Shortening the school week.
- Staggering school start and lunch/break times across year groups or classes.

**Communication and Reporting**

**49. Are schools required to report information to the local health department including cases, type and onset of symptoms, number of exposed persons, etc.?**

Yes – schools must cooperate with the LHD to provide relevant information needed for mitigating the spread of COVID-19 infection and must be reported to the LHD for use in surveillance and contacting tracing public health activities. Schools must be aware of records and confidentiality laws pertaining to school student records, including exceptions to release of information in the event of an emergency, and requirements to notify parents and create a record of emergency releases of information. (105 ILCS 10/6(a)(7); 23 Il. Admin. Code 375.60).

**50. Is there a template letter for schools to use when notifying parents/guardians, students, and staff of a case of COVID-19?**

Yes, a template letter can be found here:

<https://www.isbe.net/layouts/Download.aspx?SourceUrl=/Documents/Case-School-sample-letter.docx>.



**51. Is it a Family Educational Rights and Privacy Act (FERPA) violation to notify the LHD/IDPH or staff and parents of a confirmed or probable case(s) in our school?**

No – a laboratory confirmed case of COVID-19 is reportable within 3 hours to the Local Health Department per the [Communicable Disease Code](#). Identifiable information on a student or staff member including name and contact information, is reportable to IDPH or to the local public health authority for any notifiable disease or condition.

Schools must be aware of records and confidentiality laws pertaining to school student records, including exceptions to release of information in the event of an emergency, and requirements to notify parents and create a record of emergency releases of information. (105 ILCS 10/6(a)(7); 23 Il. Admin. Code 375.60).

**52. Does contact tracing violate the Health Insurance Portability and Accountability Act (HIPAA)?**

No. The HIPAA Privacy Rule allows for reporting by covered entities to public health for the purpose of preventing the spread of infectious diseases. HIPAA recognizes the legitimate need for public health authorities, and others responsible for ensuring public health and safety, to have access to protected health information to carry out their public health mission<sup>6,7</sup>.

**53. If we have a case of COVID-19 in a student at our school, what is our responsibility for notifying schools attended by siblings of the case? (Updated 12/2/2020)**

There is no need to notify a school attended by siblings of a sick individual. If the sick individual tests positive for COVID-19 or becomes a probable case, the LHD conducting contact tracing will place siblings in quarantine for the recommended period of time and facilitate parental notification to the school(s) attended by siblings of the case.

**54. Besides public health authorities, who should be notified of a case of COVID-19 at our school? Must we notify the entire district, or only the classroom or the building?**

Communication of a confirmed or probable case of COVID-19 to the district and school community should align with the school's policy for notification of cases of communicable diseases. The communication message should counter potential [stigma](#) and discrimination. In such a circumstance, it is critical to maintain confidentiality of the student or staff member as required by the Americans with Disabilities Act, the Family Education Rights and Privacy Act, and the Illinois School Student Records Act

**Travel Restrictions**

**55. Are there any current domestic or international travel restrictions for which we should be monitoring and excluding students and staff? (Updated 6/7/2021)**

There is widespread, ongoing transmission of novel coronavirus worldwide. CDC recommends delaying travel until the traveler is [fully vaccinated](#), because travel increases the chance of getting and spreading COVID-19. To learn more about COVID-19 travel recommendations for a specific destination for those fully vaccinated and not vaccinated, visit [COVID-19 Travel Recommendations by Destination](#).

Domestic travel guidance can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/infographic/infographic-quick-reference.html>

International travel guidance can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/infographic/infographic-international-quick-reference.html>

### **Cleaning and Disinfection**

#### **56. What kind of cleaning and disinfection should our school be doing routinely?**

Enhance your standard cleaning and disinfection practices. Increase the frequency of cleaning and disinfection with a focus on areas that are commonly touched, such as doorknobs, stairwells, light switches, elevator buttons, etc. Disinfect seats and rails on school buses at least daily. Shared objects such as toys, games, art supplies, should be cleaned and disinfected between uses. Ensure cleaning and disinfection products are EPA-approved and used safely and in accordance with label directions.

#### **57. What are exact cleaning requirements for areas used by a suspected or confirmed COVID-19 case?**

Areas used by an individual with COVID-like symptoms, e.g., examination room in the school nurses' office, should be closed off for as long as practical before beginning cleaning and disinfection to minimize potential for exposure to respiratory droplets. Outside doors and windows should be opened to increase air circulation in the area. If possible, wait up to 24 hours before beginning cleaning and disinfection. Environmental cleaning staff should clean and disinfect all areas (e.g., offices, bathrooms, and common areas) used by the ill persons with COVID-like symptoms, focusing especially on frequently touched surfaces. For disinfection, most common EPA-registered household disinfectants should be effective. A list of products that are EPA-approved for use against the virus that causes COVID-19 is available [here](#). Personnel performing environmental cleaning should use personal protective equipment (PPE) including fit-tested N95 respirator, eye protection with face shield or goggles, gown, and gloves.

### **Miscellaneous**

#### **58. Can space heaters and fan be used in the school environment (e.g., classrooms, offices, gyms, locker rooms)? (Updated 10/27/2020)**

The use of oil or water-filled radiators, ceramic, or infrared heaters wouldn't be expected to increase the risk for COVID-19 transmission. However, fan-forced heaters could present an issue. We recommend that schools consult with their building engineer before using fan-forced heaters, as well as floor fans and ceiling fans, because changing airflow patterns can limit the ability of aerosols (COVID-19 can be exhaled in droplets and aerosols) and air contaminants to enter the HVAC system.

Additional considerations related to space heater safety include the following:

- Space heaters should bear the seal of a nationally recognized testing laboratory (NRTLs), such as Underwriters Laboratories. A [Current List of NRTLs](#) is available from OSHA.
- Place space heaters at least 3 ft. from people and anything that can burn.
- Purchase a unit with overheat protection.

- Turn it off and unplug it after use.

We recommend the school develop a policy or guidelines for heaters used at their school. More information is available from the Office of the Illinois State Fire Marshal's [Portable Heater Safety](#) webpage.

### **School Toolkits and Checklists (1/4/2021)**

K-12 Schools COVID-19 Mitigation Toolkit

- [https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/FINAL-0321420\\_B\\_K-12\\_Mitigation\\_Toolkit508.pdf](https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/FINAL-0321420_B_K-12_Mitigation_Toolkit508.pdf)

K-12 School Walkthrough Guide

- <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/321420-Walkthrough.pdf>

### **Resources**

<sup>1</sup> <http://dph.illinois.gov/sites/default/files/publications/commchartschool-032817.pdf><https://www.healthychildren.org/English/family-life/work-play/Pages/When-to-Keep-Your-Child-Home-from-Child-Care.aspx>

<sup>2</sup>A "case with an epidemiological link" is a case that has either been exposed to a confirmed case or has had the same exposure as a confirmed case.

<sup>3</sup><https://www.nfhs.org/articles/covid-19-instrument-cleaning-guidelines/>

<https://issma.net/covidresources.php> (Indiana guidance may vary from Illinois)

<sup>4</sup> OSHA: <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134>

<sup>5</sup><https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/personal-protective-equipment-euas#appendix>

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/international-respirator-purchase.html>

National Association of School Nurses

[https://higherlogicdownload.s3.amazonaws.com/NASN/3870c72d-fff9-4ed7-833f-215de278d256/UploadedImages/PDFs/03182020\\_NASN\\_Facemask\\_Considerations\\_for\\_Health\\_care\\_Professionals\\_in\\_Schools.pdf](https://higherlogicdownload.s3.amazonaws.com/NASN/3870c72d-fff9-4ed7-833f-215de278d256/UploadedImages/PDFs/03182020_NASN_Facemask_Considerations_for_Health_care_Professionals_in_Schools.pdf)

<sup>6</sup><https://www.hhs.gov/hipaa/for-professionals/special-topics/public-health/index.html#:~:text=Background%20The%20HIPAA%20Privacy%20Rule%20recognizes%20the%20legitimate,information%20to%20carry%20out%20their%20public%20health%20mission>

<sup>7</sup><https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html>

