

Requirements and Guidance to Mitigate COVID-19 Transmission in K-12 Schools, Child Care, Early Learning, Youth Development, and Day Camp Programs

Summary of March 10, 2022 Changes – *Effective March 12, 2022*

- Technical change in language to clarify requirements for return after isolation.

Summary of March 7, 2022 Changes – *Effective March 12, 2022*

- As Washington K-12 instruction enters the final months of the 2021-2022 academic year, this document outlines the remaining requirements for K-12 schools, child care, early learning, youth development, and day camp programs, along with options to consider when building a framework for controlling COVID-19 and minimizing the risk of exposure in educational and child care settings.
 - [Section 1](#) outlines **required** measures.
 - [Section 2](#) and [Section 3](#) include additional options and considerations for schools and providers. These are not requirements.
 - [Section 4](#) and the [Appendix](#) include additional resources and information.
- The previous K-12 Requirements for the 2021-2022 School Year and K-12 Supplemental Considerations have been merged into one document and streamlined.
- Previous recommendations for child care, early learning, youth development, and day camp programs have been included in this comprehensive and aligned document.

For the purposes of this document:

- **Schools** refers to public and/or private schools serving kindergarten through 12th grade (K-12).
- **Providers** refers to child care, early learning, youth development, and day camp programs. For a list of programs included in this group, see the [glossary](#).

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Section 1: Requirements

Schools and providers are required to continue to adhere to the requirements in this section when applicable:

- [Employee COVID-19 Vaccination](#)
- [Exclusion of People with Symptoms of COVID-19](#)
- [At-Home Isolation Protocol and Returning to School, Care, or a Program](#)
- [Isolation of COVID-19 Cases within a Facility](#)
- [Notifying Groups or Individuals of Potential Exposure](#)
- [Ensure Access to Diagnostic Testing for COVID-19](#)
- [Reporting COVID-19 Cases and Outbreaks and Working with Public Health](#)
- [Responding to Clusters and Outbreaks](#)

Schools, districts, providers, programs, and/or LHJs may choose to put more protective policies in place, which are also required to be followed.

Employee COVID-19 Vaccination

All employees in educational settings are **required** to be fully vaccinated or have a medical or religious exemption per [Governor's proclamation 21-14.3](#).

Exclusion of Individuals with Symptoms of COVID-19

Students, children, and staff who have symptoms of [COVID-19](#), are **required** to stay home and should get tested and/or see a health care provider and follow the return to work/care/school protocol accordingly (see [At-Home Isolation Protocol and Returning to School or a Program](#) section). See also the [What to do if a Person is Symptomatic](#) flowchart as a reference.

Any student, child, or staff member who tests positive for COVID-19 is **required** to isolate at home following current guidelines from DOH (see [At-Home Isolation Protocol and Returning to School or a Program](#) section) and the [CDC](#). This isolation guidance applies regardless of vaccination status.

At-Home Isolation Protocol and Returning to School, Care, or a Program

A student, child, or staff who tests positive for COVID-19 is **required** to isolate at home, regardless of vaccination status. The isolation period is 10 full days from the start of symptoms or the date of positive test. See [Calculating Your Isolation Period](#) for additional information.

The individual may return to school/care after 5 full days of isolation if:

- Their [symptoms](#) have improved or they are asymptomatic, AND
- They are without a fever for the past 24 hours without use of fever-reducing medications.

AND IF returning to school/care days 6-10, the individual is **required** to:

- Wear a well-fitted mask or face shield with a drape during days 6-10 of their isolation period, consistent with CDC guidance, **OR**
- Test negative with an antigen or at-home test any day after day 5 before returning without a mask. Testing beyond day 10 is not necessary.

If the individual is not able to wear a well-fitted mask or face shield with a drape, AND does not test negative, they are **required** to continue isolating through the end of their isolation period.

See also the [What to do if a Person is Symptomatic](#) flowchart as a reference.

Isolation of COVID-19 Cases within a Facility

Any student, child, or staff who reports or exhibits [COVID-19-like symptoms](#) is **required** to be immediately isolated from others, sent home, and referred to diagnostic testing as soon as feasible, regardless of vaccination status. While waiting to leave the school or program, the individual with symptoms is **required** to be isolated in a designated isolation space. They are **required** to wear a well-fitting face mask, if tolerated and age appropriate. Anyone providing care or evaluation to the isolated individual is **required** to wear [appropriate PPE](#).

Masks are **required** by all children, staff, and visitors aged 2 years and older in the nurse/health room and in the isolation room as these are considered health care settings. Staff may require a certain level of respiratory protection when working with individuals in isolation who are known or suspected to have COVID-19. Refer to L&I's [Coronavirus Facial Covering and Mask Requirements](#) for additional details.

The designated isolation space for individuals with COVID-19-like symptoms is **required** to be separated from the space used for those requiring general first aid or medicine distribution in a school setting, or from shared space with other children in a child care/early learning setting. For schools, if the nurse’s office has an exam room designed with a negative air flow and directly exhausted air, this room should be given priority as an isolation space. If this is not available, the isolation space would ideally be a room with a door that can close and a window that can be opened to improve ventilation. A properly sized HEPA air filter could be used to increase filtration, see [DOH ventilation guidance](#) for more information.

If no appropriate indoor space is available (e.g., already occupied) and the student or child can be supervised and made comfortable, an outdoor setting is an acceptable emergency alternative if weather and privacy permit.

Notifying Groups or Individuals of Potential Exposure

Staff are **required** to be notified of exposure following the requirements in [WAC 296-62-600](#). See the L&I guidance document [Questions and Answers: Reporting and Notification Requirements of HELSA and PPE Usage](#).

In addition, schools and providers are **required** to directly notify any student who has been identified as immunocompromised, medically fragile, or otherwise at [high risk](#) for severe COVID-19 of potential exposure. Notification should be provided to all employees and high risk individuals, irrespective of their vaccination status or recent infection within the past 90 days.

For the rest of the general school and youth-serving population, schools and providers are **required** to have a process in place to inform students, children, families, and staff when there are cases or outbreaks in the school. Use communications in the language that families can understand. Always and when resources are limited, concentrate notification efforts to inform medically fragile students, children, families, and staff, including any others at high risk.

Below are options for keeping families informed of cases and outbreaks:

- Weekly newsletters or online dashboards of cases or outbreaks.
- Notification (e.g., by email or messaging system) of “groups” rather than individual “close contacts.” These groups could include classmates, teammates, grade levels, cohorts, bus riders, or others.
- Group notifications may also be appropriate in times of a cluster or outbreak.
- There may be instances where individual contact tracing may be required (e.g., during an outbreak). Consult with your LHJ.

Regardless of vaccination status, students, children, and staff who were potentially exposed to COVID-19 should be encouraged to:

- Monitor for [symptoms](#), AND
- Consider wearing a well-fitted mask (if age appropriate) for 10 days after the last date of exposure, especially during activities like high-risk indoor sports, performing arts, etc., AND
- Get tested 3-5 days after their last exposure. Molecular (PCR/NAAT), antigen, and at-home tests are acceptable. If they test positive, they must [isolate](#).

- For individuals who have been recently infected (within the past 90 days), antigen testing should be performed as PCR results may remain persistently positive and not be indicative of a new, active infection.

See also the [What to do if You Receive an Exposure Notification](#) flowchart as a reference.

Exposed students, children, and staff may continue to take part in all in-person instruction and care, including sports, performing arts, and other extracurricular activities, as long as they are not symptomatic. If an exposed student, child, or staff develops symptoms, they are **required** to immediately isolate at home follow the protocols outlined in the [Exclusion of People with Symptoms of COVID-19](#) section.

Ensure Access to Diagnostic Testing for COVID-19

K-12 schools are **required** to ensure access to timely diagnostic testing for students and staff with symptoms or who were potentially exposed and want to test. This can be done at the school, at a centralized site for the district, and/or in partnership with a trusted and accessible community-based testing provider and local public health. Timely testing of symptomatic students and staff helps reduce days of in-person instruction lost. Additionally, symptomatic individuals with negative COVID-19 test results may be able to return to school earlier. Molecular (PCR/NAAT), point of care (POC) antigen, and at-home tests are acceptable.

DOH's [Learn to Return](#) testing program is available to help K-12 schools meet diagnostic testing requirements. Schools or districts that would like more information about COVID-19 testing programs should contact schools@healthcommonsproject.org. See the DOH [Testing in Schools](#) page for more information.

Reporting COVID-19 Cases and Outbreaks and Working with Public Health

Schools and providers play an important role in identifying COVID-19 cases and limiting the spread of COVID-19. All cases of COVID-19 in schools and provider facilities are **required** to be reported to [LHJs/DOH](#) in accordance with LHI/DOH guidance and Washington State law ([WAC 246-101](#)). All outbreaks of COVID-19 are **required** to be reported to the LHI/licensor ([WAC 246-101](#)). COVID-19 test results should be reported to DOH in accordance with guidance available at the [Reporting COVID-19 Test Results](#) webpage. In addition, schools, providers, and the general public are **required** to cooperate with public health authorities in the investigation of cases and outbreaks that may be associated with the school or provider ([WAC 246-101](#)).

Employers are **required** to notify L&I about outbreaks of 10 or more staff members at a facility. See the L&I guidance document [Questions and Answers: Reporting and Notification Requirements of HELSA and PPE Usage](#).

Responding to Clusters and Outbreaks

Clusters and outbreaks represent situations in a school or provider setting where, in coordination with local public health, enhanced mitigation efforts including some of the strategies outlined in [Section 2](#) should be considered, and **may be required**, to prevent disease transmission.

Section 2: Information on Optional Strategies for Layered Prevention

The Washington Department of Health (DOH) encourages schools to coordinate with their local health jurisdiction (LHJ) for any decisions related to the strategies outlined herein. While we are moving into a new phase of the pandemic, COVID-19 remains with us, and it should be recognized the COVID-19 pandemic response must remain flexible with the possibility for changes that occur at the state and local levels. **Conditions may require implementation of additional mitigation practices to lessen the impact of disease in schools and provider settings, and to ensure continuity of in-person instruction and care.**

Successfully limiting transmission of COVID-19 and maximizing in person instruction relies on communication between schools, providers, and local public health authorities. Some of this communication may include private information that falls under the Family Educational Rights and Privacy Act. [FERPA](#) allows schools to share personally identifiable information with local public health without consent when responding to a health emergency.

The following information is based on existing science^{1,2} and information from the Centers for Disease Control and Prevention's (CDC) [Guidance for COVID-19 Prevention in K-12 Schools and COVID-19 Guidance for Operating Early Care and Education/Child Care Programs](#).

Evidence to date suggests that when prevention strategies are layered and implemented with fidelity, transmission rates within schools and provider programs can be limited. Further, transmission of SARS-CoV-2 (the virus that causes COVID-19) in the community is correlated with incidence of infected individuals in schools and provider settings. When community rates of COVID-19 are high, there is an increased likelihood that SARS-CoV-2 will be introduced to, and potentially transmitted within, a school or provider setting.

Lessons learned over the first two years of the pandemic have identified the importance of the following to prevent COVID-19 transmission and related outbreaks:

- Staying up to date on [vaccinations](#).
- Wearing [masks](#) for personal protection and source control.
- Enhancing [ventilation](#) to reduce transmission of aerosolized viruses.
- Remaining at home when ill.
- Conducting rapid diagnostic testing.
- Exercising good [respiratory etiquette and hand hygiene](#).
- Practicing [physical distancing](#) to the degree possible and practical.
- [Cleaning and disinfecting](#) as indicated.
- Maximizing outdoor activities.

Schools and providers need to maintain flexibility in how layers of mitigation practices are applied. Removal of a layer of protection should be done factoring in considerations such as community levels of transmission, local outbreaks, and vaccination rates. Schools and providers should also ensure an environment that supports individuals who choose to continue a protective practice, like wearing a mask. As disease prevalence increases, schools and providers

¹ [Science Brief: Transmission of SARS-CoV-2 in K-12 Schools and Early Care and Education Programs - Updated | CDC](#) https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/transmission_k_12_schools.html (Accessed 03/06/2022)

² <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/indicators-monitoring-community-levels.html> (Accessed 03/06/2022)

should consider adding back in additional layers of prevention or mitigation measures. Coordination with local public health will ensure this is done in the way to best ensure the safety of students, children, employees, families, and the community.

Individuals who choose to continue to use preventative measures to protect themselves should be supported. Assumptions regarding someone's beliefs or health status should neither be made nor commented about. Schools and programs should not tolerate harassment or bullying of any kind.

Vaccination

Vaccination is the most effective prevention strategy available to protect vaccine-eligible children and adults from the most severe outcomes due to COVID-19 illness. As noted above, all employees in educational settings must be fully vaccinated or have a medical or religious exemption per [Governor's proclamation 21-14.3](#).

Schools and providers should promote staying [up to date](#) on all vaccinations for eligible students, children, staff, and families – including COVID-19 vaccination. DOH created the [COVID-19 Vaccine School Toolkit](#) to provide materials and resources to schools to help them answer parent questions and promote COVID-19 vaccination. DOH also created a [COVID-19 Vaccine Clinic Toolkit for Schools](#) to help schools coordinate vaccine clinics with community partners and promote COVID-19 vaccination. Both toolkits can be found on DOH's [School and Child Care Immunization](#) page.

See also the [CDC's guidance](#) on [how schools can promote vaccinations](#). Visit [DOH's Vaccine Information](#) webpage for general information about COVID-19 vaccines, including the [vaccine locator](#) tool.

Masks

Correct use of well-fitting masks or face coverings protects the wearer as well as others, thereby helping to prevent transmission of COVID-19.

While masks are no longer required universally in schools or provider settings, there will be situations when the use of well-fitting masks may be temporarily required for individuals by DOH and/or local public health (e.g., days 6-10 when a student, child, or staff returns from isolation after 5 days unless they have tested negative per [At-Home Isolation Protocol and Returning to School or a Program](#) section). Masks may also be required universally during clusters and/or outbreaks in classrooms or with groups of students (e.g., a choir class or a sports team), or within provider settings, to limit disease transmission and ensure in-person instruction and care (see [Responding to Clusters and Outbreaks](#) section).

Students, children, and staff will have the choice to wear a mask at school and/or at provider settings, with the expectation that others' choices will be respected. Some may need to wear a mask because they or a member of their household is [high risk](#) for severe COVID-19 disease.

Students, children, and staff who are immunocompromised, medically fragile, and/or otherwise high risk for severe disease should consult their health care provider about whether or not to continue wearing well-fitted masks. Staff who provide for students and children with disabilities that requires close contact should strongly consider wearing appropriate PPE when providing care. In addition, schools should leverage recommended mitigation measures in

meeting the needs of their high-risk populations, following all existing state and federal laws in doing so.

Schools and providers should provide masks and other appropriate PPE to staff, students, and children as needed or desired.

While correct use of well-fitting masks helps prevent the spread of COVID-19, there are specific exceptions to mask recommendations based on age, development, or disability. See [DOH's Guidance on Face Coverings](#) and [CDC Recommendation Regarding the Use of Face Coverings](#) for more information. Employees have the right to choose to mask or select more protective masks. Refer to L&I's [Coronavirus Facial Covering and Mask Requirements](#) for additional details.

Screening Testing

Screening testing (one-time or weekly cadence) for students, children, and staff are not required but can assist in identifying individuals who may be infected and contagious. Identification can lead to decreasing transmission by ensuring prompt isolation of cases to limit onward spread of disease.

In addition to required access to diagnostic testing, the [Learn to Return](#) program can also support screening testing for students and/or staff among schools who choose to layer this strategy. Schools or districts who would like more information about COVID-19 testing programs should contact schools@healthcommonsproject.org.

Testing resources for providers may be requested through LHJs. Visit DOH's [COVID-19 Testing](#) page for general information on how to get test kits, including at-home tests, and where to get tested.

Test to Stay

Many schools, in coordination with local public health, have established robust Test to Stay programs as an alternative to at-home quarantine in an effort to keep children in school and provider programs if they are not ill or positive for COVID-19. While contact tracing is no longer required, schools may continue existing testing programs to ensure uninterrupted, full-time, in-person learning.

Considerations for engagement in Test to Stay protocols include, but are not limited to:

- Higher risk exposures [e.g., high-risk indoor sports, high aerosol-generating activities (e.g., indoor cheer, singing, or playing brass or woodwind instruments), working out in a training room, or when evaluating ill individuals].
- Household exposures, which provide opportunities for prolonged and repeated exposures.
- Known exposure of an individual not up to date on COVID-19 vaccinations.
- Individuals who are at high risk for significant disease.
- During clusters and outbreaks to maintain in-person instruction.

Test to Stay Protocol

Individuals may continue to attend work, class, child care, and participate in extracurricular activities while completing a Test to Stay protocol, if they:

- Are tested* serially over a 10-day period (e.g., twice per week) of the protocol AND
- Are asymptomatic.

Individuals completing a Test to Stay protocol are strongly recommended to monitor for symptoms and wear a well-fitting mask when around others. If an individual tests positive for COVID-19 at any time, they must isolate at home and follow DOH [isolation guidance](#).

*Antigen tests, point of care (POC) molecular tests, or at-home tests are acceptable and preferred, given the ability to obtain results within minutes and the need to identify positive individuals and isolate in a timely fashion.

Collection of diagnostic specimens for asymptomatic persons during a Test to Stay protocol may occur in schools, health care settings, or other locations supervised by school or health care personnel.

School districts must receive permission from parents/guardians for students to receive school-based testing.

Ventilation

Good ventilation, filtration, and indoor air quality are important in reducing airborne exposure to respiratory pathogens, including COVID-19, as well as chemicals, and odors.

DOH recommends the following ventilation practices:

- Upgrade filters to MERV 13 if the system can handle the air resistance.
- Bring in as much outside air as possible – through the HVAC or by opening windows.
- Consult with a professional engineer or HVAC specialist to determine the best way to maximize the system’s ventilation and air filtration capabilities for each area in the building.
- Cooling fans may be used. They should blow away from people. If there are ceiling fans, reverse the flow direction to draw air upward or turn them off.
- Portable HEPA air cleaners can provide increased filtration in rooms with poorer ventilation or in isolation areas. Choose HEPA air cleaners certified by the California Air Resources Board to not emit dangerous levels of ozone. Do not use ozone generators, electrostatic precipitators and ionizers, negative ion air purifiers, etc. because they can produce harmful by-products. Do not use personal air purifiers.

For more information and options related to ventilation, see DOH’s [Ventilation and Air Quality for Reducing Transmission of COVID-19](#), [CDC’s guidance for improving ventilation and increasing filtration](#) in schools, and the [Association for Heating, Ventilating and Air-Conditioning Engineers \(ASHRAE\) guidance on ventilation during COVID-19](#).

Physical Distancing

Physical distancing should not prevent a school from offering full-time, in-person learning to all students/families, nor should it prevent a provider from providing care. Select strategies to increase physical distancing that will work for your school and program in the space available. There may be moments, such as passing by others in the hallway or during play at recess when students and children are not fully physically distanced from each other. Maximize opportunities to increase physical space between students and children to the degree possible during all scheduled activities and limit interactions in large group settings.

Maximize distance between students and children to the degree possible for the following circumstances:

- When in the cafeteria.
- In common areas outside of the classroom.
- During high-risk activities when increased exhalation or aerosolization occurs (e.g., PE or exercising indoors, singing or playing instruments, and cheering or shouting). These activities should be moved outdoors or to large, well-ventilated spaces whenever possible.

Schools and providers must adhere to existing licensing rules regarding group size and staffing ratios.

Bus Transportation

Strategies to reduce risk of COVID-19 transmission during school and provider transportation include:

- Consider wearing well-fitting masks.
- Keeping riders as far apart as possible on the bus.
- Maximize ventilation on the bus by keeping at least 2 front and 2 rear windows open a few inches.
- Do not fog/mist the bus with disinfectant. Leave windows open to air out the bus after runs and clean as needed.
- Encourage walking or biking where safe.
- Encourage students to wash or sanitize hands when they leave their home or classroom before boarding the bus.

Handwashing and Respiratory Etiquette

Schools and providers should continue to encourage frequent handwashing and good respiratory etiquette to prevent contracting and spreading infectious diseases, including COVID-19. Through ongoing health education units and lessons, teach children proper handwashing and reinforce behaviors. Support [healthy hygiene](#) behaviors by providing adequate supplies, including soap, a way to dry hands, tissues, and no-touch/foot-pedal trash cans. Ensure that staff practice proper handwashing and respiratory etiquette.

Cleaning and Disinfection

Clean and disinfect high-touch surfaces like doorknobs, faucet handles, check-in counters, drinking fountains, and restrooms. In general, cleaning once a day is enough to sufficiently remove potential virus that may be on surfaces. Desks can be cleaned with soap and water. Desks only need to be disinfected for vomit, blood, or feces, or during an outbreak. Wash hands after you clean.

Sanitizers and disinfectants must be EPA registered anti-microbial pesticides. If they are not EPA registered, they are not an appropriate product. For COVID-19, choose a disinfectant registered for use against the [SARS-CoV-2 virus](#). When possible, choose safer fragrance-free disinfectants and sanitizers. Hydrogen peroxide or alcohol-based products are safer for human health and are better products for those who suffer from asthma.

General safe practices:

- Use disinfectants in a ventilated space. Heavy use of disinfectant products should be done when children are not present. The facility should have enough time to air out

before individuals return (i.e., at the end of the day).

- Use the proper concentration of disinfectant.
- Always preclean surfaces before applying disinfectant.
- Keep the disinfectant on the surface for the required amount of wet contact time.
- Follow the product label warnings and instructions for PPE such as gloves, eye protection, and ventilation.
- Keep all chemicals out of reach of children. Children under 18 years of age cannot use EPA registered sanitizers and disinfectants, including disinfectant wipes.
- Facilities must have a Safety Data Sheet (SDS) for each chemical used in the facility.
- Parents and staff should not supply disinfectants and sanitizers.
- Use alcohol wipes or 70% isopropyl alcohol to clean keyboards and electronics.
- Do not use fogging, fumigation, or wide-area spraying to control the spread of COVID-19. These methods are not effective, do not clean contaminated surfaces, and are hazardous to human health.

Find more information about cleaning, disinfecting, and choosing safer cleaning and disinfection products on the [Safe Cleaning and Disinfection Guidance for Public Spaces](#).

Section 3: Supplemental Considerations

Behavioral & Mental Health

Feeling anxious about changes in school/provider routines, such as the discontinuation of masking, or when disease levels rise, is normal and expected. The experiences of children, teens, families, and staff during the COVID-19 pandemic has frequently been complicated and challenging; and has had an impact on bodies, minds, and emotions. As children, teens, parents, caregivers, and school staff navigate the next phase of the pandemic and what that means for schools and families, these factors may impact their individual emotional functioning. Some students will be relieved and happy, but others may feel anxious and not ready for the changes. It will take time for everyone to adjust. It will be important to provide support and guidance for students, to allow time for them to adjust to new guidelines, and to offer permission for youth and staff to continue to wear masks or physically distance if they feel uncomfortable with the changes.

The [Behavioral Health Toolbox for Families: Supporting Children and Teens During the COVID-19 Pandemic](#) provides general information about common emotional reactions of children, teens, and families during disasters. It also has suggestions on how to help children, teens, and families recover from disasters and grow stronger.

The [COVID-19 Back-to-Classroom THINK Toolbox](#) provides behavioral health tips and resources for navigating some of the common emotional responses of children, teens, and adults during disasters and how these may present in the classroom and other areas of life.

Check the [DOH's Behavioral Health Resources & Recommendations](#) and the [Washington State COVID-19 Response: Mental and emotional well-being](#) webpages for additional resources.

Additional resources:

- [Behavioral Health Monthly Forecasts](#)
- [Recognizing and Reporting Child Abuse and Neglect in Online Education Settings](#)

- [Coping with Grief and Loss During COVID-19](#)
- [Behavioral Health Support Guidance for Children, Youth, and Teens in Crisis](#)

Equity

A person's race/ethnicity or nationality does not, itself, put them at greater risk of COVID-19. However, data collected during the last two years has shown that communities of color are disproportionately impacted by COVID-19. This is due to the effects of racism, and in particular, structural racism, that leaves some groups with fewer opportunities to protect themselves and their communities. [Stigma will not help to fight the illness](#). Share accurate information with others to keep rumors and misinformation from spreading. See [Stigma Reduction Resources](#).

Individuals at High Risk and Those with Disabilities

Those at [high risk](#) for health problems from COVID-19 should consult with their health care provider when considering how to participate in school, child care, youth development opportunities, or day camps. See L&I's [FAQ for Protecting High Risk Workers](#) for more information.

When serving children or youth with disabilities, refer to the [CDC guidance for Direct Service Providers for people with disabilities](#).

Infant and Toddler Care

Infants and toddlers need to be held. To the extent possible when holding, washing, or feeding young children, child care workers should:

- Wash their hands frequently.
- Wash their hands, neck, and anywhere touched by a child's body fluids.
- Avoid touching eyes while holding, washing, or feeding a child.
- If body fluids get on the child's clothes, change them right away, whenever possible, and then wash hands.
- Wash hands before and after handling infant bottles prepared at home or in the facility.

Returning to School or a Program after Travel

Travelers should refer to [CDC travel guidance](#) for information. Schools and programs should consider integrating recommendations from the CDC into their policies. Communicate with parents and guardians the expectations for returning to school or a program after traveling.

Screening Testing for Events and/or After Breaks

Schools and programs may consider 'return' testing following summer, winter, spring, or other holiday breaks or ahead of large events/gatherings to minimize risk of transmission among the school and provider populations. Testing should be done in a way that does not interfere with or disrupt instruction or delivery of care. At-home tests can be an acceptable option.

Performing Arts

High aerosol-producing performers [e.g., singers, woodwinds and brass, speech/debate, dance (competitive and dance squads) and theatre performers] should consider wearing appropriate masks and/or use appropriate bell covers while practicing and/or performing.

- Bell covers with appropriate material – MERV 13 or 3-layer medical face mask or similar material – are recommended for:
 - Brass and woodwind instruments when indoors.
 - The end or barrel of a recorder when indoors.
- Masking with appropriate material – 3-layer medical face mask or similar material – should be considered in general music and elementary classrooms when singing is performed. Staff may provide students with a mask designed to fit snugly while allowing for facial movement during singing.

Performers, directors, and other support personnel should physically distance indoors to the degree possible. Ensure that all students have access to their chosen performing arts course. Space constraints should not limit access to these classes.

- The use of cohorts within a performing arts activity group limits the potential for group-wide transmission in the event of an exposure or outbreak.

Maximize ventilation of the space as much as possible. If a space is smaller and/or not well-ventilated, consider using portable HEPA air cleaners to supplement. See also [Ventilation](#) above for best practices to allow appropriate time for air change.

Practice good hygiene collecting water condensation from brass instruments. Consider using absorbent pads for students to empty spit valves rather than emptying directly on the floor.

Athletics

Maximize ventilation of indoor space as much as possible. If a space is smaller and/or not well-ventilated, consider using portable HEPA air cleaners to supplement or moving the activity outdoors. See also [Ventilation](#) above for best practices to allow appropriate time for air change.

Athletes, coaches, athletic trainers and other support personnel should consider wearing masks when participating in indoor activities, especially high-risk indoor sports (e.g., basketball, wrestling, water polo, indoor cheer), where aerosolization may occur and the indoor space is not well ventilated; and should distance to the degree possible whenever not playing.

- The use of cohorts within the team limits the potential for team-wide transmission in the event of an exposure or outbreak and should be considered for practices, warm-ups, and when traveling.

Screening Testing for Sports, Performance Arts, or Other Activities/Events

To promote safer participation in school-sponsored activities, schools may implement screening testing protocols for all athletes in high-risk indoor sports (e.g., basketball, wrestling, water polo, indoor cheer), performing arts (e.g., choir, band, theatre), and/or other activities.

- Screening testing of participants can be performed either at a regular weekly cadence (e.g., once or twice per week) or be performed on the day of the production, competition, or event. Individuals who tested positive for COVID-19 in the past 90 days and recovered do not need to participate in screening testing unless symptomatic, at which time an antigen test is recommended.
- All participants in indoor low- or moderate-risk sports, or other activities, may also participate in screening testing. This is especially important when community levels are high. Please see the [CDC's COVID-19 community levels](#) for more information.
- Any athlete, performer, or staff member with a positive test is required to isolate and

should not participate in training, rehearsal, competitions, productions, or events during their isolation period. Follow the [Exclusion of People with Symptoms of COVID-19](#) and [Isolation of COVID-19 Cases](#) sections above for more information. [Exposure notification](#) of the team as a group may be warranted. [Report cases](#) as required.

Other Co-curricular or Extracurricular Activities (CTSOs, Clubs, Interest Groups, STEM Fairs, Field Trips, etc.)

Students, children, staff, support staff, and volunteers should consider the guidelines within this document when hosting or participating in school- or program-sponsored activities, contests, shows, etc., to minimize the risk for COVID-19 transmission.

Section 4: COVID-19 Information and Resources

Additional COVID-19 Resources for Schools and Providers

- DOH: [What to do if you test positive for COVID-19](#)
- DOH: [What to do if you were potentially exposed to someone with COVID-19](#)
- DOH: [Handwashing to Prevent Illness at School](#)
- DOH: [Classroom Cleaning - Tips for Teachers](#)
- DOH: [Cleaning and Disinfection for Asthma Safe Programs](#)
- L&I: [Workplace Safety and Health Requirements for Employers](#)
- L&I: [Which Mask for the Task?](#)
- CDC: [Guidance for COVID-19 Prevention in K-12 Schools](#)
- CDC: [Operating Child Care Programs during COVID-19](#)
- CDC: [Small and Large Gatherings](#)
- AAP: [Cloth Face Coverings for Children during COVID-19](#)
- OSPI: [COVID-19 guidance and resources for schools](#)
- NFHS: [International Coalition of Performing Arts Aerosol Study Report 3](#)

General COVID-19 Resources

Stay up-to-date on the [current COVID-19 situation in Washington](#), [Governor Inslee's proclamations](#), [symptoms](#), [how it spreads](#), and [how and when people should get tested](#). See our [Frequently Asked Questions](#) for more information.

- [WA State Department of Health 2019 Novel Coronavirus Outbreak \(COVID-19\)](#)
- [WA State Coronavirus Response \(COVID-19\)](#)
- [Find Your Local Health Department or District](#)
- [CDC Coronavirus \(COVID-19\)](#)

Have more questions? Call our COVID-19 Information hotline: **1-800-525-0127**

Monday – 6 a.m. to 10 p.m., Tuesday – Sunday and [observed state holidays](#), 6 a.m. to 6 p.m. For interpretative services, **press #** when they answer and **say your language**. For questions about your own health, COVID-19 testing, or testing results, please contact a health care provider.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.

Appendix A: Glossary of Terms

Asymptomatic: A person showing no [symptoms of COVID-19](#) illness.

Asymptomatic surveillance testing: Testing of an individual who is without symptoms to monitor disease occurrence in a group or population.

Case investigation: Part of the process to support people who have confirmed or suspected COVID-19. Public Health staff work with an individual to identify close contacts who might become sick with COVID-19, give information about how to stay safe and healthy, help people check for symptoms, connect people with resources to safely isolate or quarantine, and stop the spread of COVID-19.

Close contact: A close contact is someone who was exposed a COVID-19 case. A close contact is generally defined by CDC and DOH as someone who was within 6 feet of a COVID-19 case for 15 cumulative minutes or more over a 24-hour period of time during the case's infectious period.

In a K-12 indoor or outdoor classroom, the close contact definition may exclude individuals who were at least three feet away from an infected individual when both were consistently and correctly wearing well-fitting face coverings/masks.

The definition of a close contact may vary in some situations (e.g., less time spent in close proximity to an unmasked person who is coughing, direct cough/sneeze spray, or other contact that is more intense like sharing drinks, eating utensils, etc.). The ultimate determination of close contact is made by the LHJ during its investigation; it may delegate this determination if appropriate.

Cohort: An assigned, small group (of students) with dedicated staff who remain together throughout the day. The students, children, and staff in a cohort should remain consistent from day to day and should not mix with other cohorts.

Contact tracing: The process of interviewing a COVID-19 case to identify people who have been exposed to COVID-19 and notifying these close contacts about their exposure, while protecting confidentiality, in order to provide public health guidance. Contact tracing helps public health track and prevent the spread of COVID-19. Please see the [Symptom Decision Tree for Schools and Providers](#) and [COVID-19 Contact Tracing Guide and FAQ for Schools and Providers](#) for additional information.

COVID-19: Coronavirus disease 2019 (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus. Individuals who have been infected may be without symptoms (asymptomatic) or present with the following [symptoms](#). The virus is thought to spread mainly from person to person:

- Between people who are in close contact with one another (within about six feet or two meters), especially indoors and if spaces are crowded and/or have poor ventilation.
- Through droplets and airborne particles formed when a person who has COVID-19 coughs, sneezes, sings, talks, or breathes. These droplets and airborne particles can remain suspended in the air and be breathed in by others, and travel distances beyond six feet (for example – during choir practice, in restaurants, or in fitness classes).

COVID-19 case: For the purposes of this document, at a minimum, a COVID-19 case is a person with a molecular- or antigen-positive COVID-19 test. Consult with your LHJ to determine if they

would like additional individuals to be included in this definition in order to determine when contact tracing should be performed or when schools should report cases to LHJs (e.g., probable cases who are close contacts of a molecular- or antigen-positive person, have symptoms of COVID-19, and have not been tested).

COVID-19 cluster:

DOH defines a cluster of COVID-19 in a K-12 setting as:

- Multiple probable or confirmed COVID-19 cases comprising at least 10% of students, teachers, or staff within a specified core group¹

OR

- At least 3 cases within a specified core group¹ meeting criteria for a probable or confirmed COVID-19 case;

AND

- Cases have symptom onset or positive test result within 14 days of each other, AND
- Cases were not identified as close contacts of each other in another setting (i.e., household) outside of the school setting

COVID-19 outbreak:

DOH and the CDC define an outbreak of COVID-19 in a K-12 setting as:

- Multiple probable or confirmed COVID-19 cases comprising at least **10% of students, teachers, or staff within a specified core group¹**

OR

- At least **3 cases within a specified core group¹** meeting criteria for a probable or confirmed COVID-19 case;

AND

- Cases have symptom onset or positive test result within 14 days of each other, AND
- Cases were not identified as close contacts of each other in another setting (i.e., household) outside of the school setting, AND
- Cases were epidemiologically linked in the school setting or a school-sanctioned extracurricular activity²

¹ A “core group” includes but is not limited to extracurricular activity², cohort group, classroom, before/after school care, etc.

² A school-sanctioned extracurricular activity is defined as a voluntary activity sponsored by the school or local education agency (LEA) or an organization sanctioned by the LEA. Extracurricular activities include, but are not limited to, preparation for and involvement in public performances, contests, athletic competitions, demonstrations, displays, and club activities.

DOH defines an outbreak of COVID-19 in a child care setting as:

- Two or more COVID-19 cases who tested positive by a viral test, AND
- At least two cases have symptom onsets (or positive test specimen collection dates if asymptomatic) within 14 days of each other, AND
- Cases were epidemiologically linked in the child care setting or a child care-associated activity (e.g., field trip), AND
- There is no plausible epidemiological linkage suggesting transmission is more likely to have occurred in another setting (e.g., household) outside of the child care setting.

Disinfecting: Disinfecting means using chemicals to kill germs that might be on a surface. The Environmental Protection Agency (EPA) has a [list of disinfectants](#) that can be used to kill the virus that causes COVID-19.

Exposure: When an individual has close contact with a person with COVID-19 who is symptomatic or asymptomatic (see close contact definition above).

Exposure Notification is a notification by text, email, phone call, or other communication of a potential exposure. This notice may come based on contact tracing or more generally because a person was in an area (e.g., on a bus or in a classroom) with someone who tests positive of COVID-19, regardless of length of exposure or distance between the individuals, meaning the notified individual may or may not meet the technical definition of a close contact.

Hand hygiene: Frequent washing with soap and water for at least 20 seconds or using alcohol-based hand sanitizer with at least 60% alcohol.

High risk for severe disease: People who are more likely than others to become severely ill if they contract COVID-19 infection.

Infectious period: The time period when a person is most likely to spread the virus to other people. Also referred to as when someone is contagious. The infectious period of someone with COVID-19 starts two days before the start of symptoms or is estimated as starting two days before the test specimen collection date if a person with COVID-19 does not exhibit symptoms. The infectious period extends to the end of a person's isolation period.

Isolation is when someone who has COVID-19 symptoms, or has tested positive, stays home and away from others (including household members) to avoid spreading their illness.

Local Health Jurisdiction (LHJ): A local health jurisdiction is the local county or district agency providing public health services to persons within the area.

Masks: A well-fitting mask is anything that completely covers your mouth and nose and fits securely on the sides of your face and under your chin. It should be made of two or more layers of tightly woven fabric with ties or straps that go around your head or behind your ears. A face shield with a drape can be used by people with developmental, behavioral, or medical conditions that prevent them from wearing a face covering.

Personal Protective Equipment (PPE): Personal protective equipment, commonly referred to as PPE, is equipment worn to minimize exposure to hazards that cause serious injuries and illness. Specific PPE is used to prevent the spread of COVID-19. Certain PPE may be needed in different spaces depending on the level of exposure to others.

Physical distancing: Also known as social distancing, this is the practice of minimizing close contact with other people.

Providers: In this document, "*providers*" is the term used to include the following program types:

- DCYF licensed child care programs and the Early Childhood Education and Assistance Program (ECEAP).
- Licensed-exempt programs operated in a manner that complies with the child and staff cohorting and group size recommendations in this guidance.
- Federally funded Head Start programs.

- Day camps, including specialty camps like sports camps.
- Outdoor preschool programs, including part day license exempt programs.
- Parent cooperatives.
- Youth Development programs providing child care and other basic supports to assist children and youth access to remote K-12 instruction.
- Expanded learning opportunities, including programs for youth that complement academic and/or social emotional learning, such as Boys & Girls Clubs, YMCA programs, and other culturally-based and identity-based programs.
- Programs funded under the federal Nita M. Lowery 21st Century Community Learning Centers program.
- Enhanced learning academies, such as formal mentoring programs, tutoring centers, and college preparatory programs.
- Child care, youth development, and day camps held in K-12 facilities.

Outbreak: See “COVID-19 Outbreak” above.

Quarantine is when someone who has been exposed to COVID-19 stays home and away from others for the recommended period of time in case they were infected and are contagious. Quarantine becomes isolation if the person later tests positive for COVID-19 or develops symptoms.

SARS-CoV-2: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is a virus that causes coronavirus disease 2019 (COVID-19). The virus has [variants](#) that have been identified. DOH conducts sequencing to track [variants in Washington State](#).

Source control: While PPE helps reduce the wearer’s exposure from breathing in air that may contain contaminants, source control refers to the use of masks to reduce the spread of respiratory droplets so that others have less chance of being exposed – especially by someone who is infected but does not know it. Respiratory protection, like PPE, protects the wearer; source control protects others.

Symptoms of COVID-19: Initial common symptoms include new loss of taste or smell, fever (higher than 100.4 F or 38 C), cough, and shortness of breath, as well as chills, headache, fatigue, muscle aches, sore throat, congestion or runny nose, nausea, and diarrhea.

Test to Stay (TTS): A protocol in which a student or staff completes post-exposure testing at regular intervals over a limited period of time in order to remain in school/child care so long as they remain asymptomatic and continue to test negative.

Testing for COVID-19: There are different tests available for COVID-19.

Two types of **diagnostic** tests can be used to confirm an active case of COVID-19:

- **Molecular test:** Molecular tests amplify bits of viral RNA so that viral infection can be detected. These tests are also referred to as nucleic acid amplification tests ([NAAT](#)). The most commonly used molecular test is the Reverse Transcription Polymerase-Chain Reaction, or RT-PCR. It is used to identify and bind to the genetic material of SARS-CoV-2, the virus that causes COVID-19 illness. This category of diagnostic test also includes loop-mediated isothermal amplification (LAMP), and clustered, regularly interspaced short palindromic repeat (CRISPR)-based assays.

- **Antigen test:** This test binds to proteins on the surface of SARS-CoV-2, the virus that causes COVID-19. They detect the presence of a specific viral antigen, which implies current viral infection. Antigen tests are currently authorized to be performed on nasopharyngeal or nasal swab specimens. Antigen tests are used to diagnose cases of COVID-19 infection and can be used in screening of individuals without infection, providing a more rapid turn-around time for results than RT-PCR tests.

A third type of test is an **antibody test**, which shows if a person has previously been infected with COVID-19. It identifies antibodies to SARS-CoV-2, the virus that causes COVID-19 illness. Antibody tests are not used to diagnose current cases of COVID-19.

Point-of-care (POC) tests use rapid diagnostic tests performed or interpreted by someone other than the individual being tested or their parent or guardian and can be performed in a variety of settings. Rapid tests used in point-of-care settings can be NAAT, antigen, or antibody tests.