

Section 504 Accommodation Plan

for Student: _____

DOB: _____

Date: _____

for

Accommodations Related to:

Child and Household At Risk of Serious Adverse Health Outcomes if Infected with COVID-19

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This guide was modified from the [World Health Network's Guide to Section 504](#)

Parental Statements:

- I. My child/household is at risk for serious adverse health outcomes if infected with COVID-19, and in order to manage risks so that they can concentrate on schoolwork, he/she/they require reasonable accommodations.

More Information:

Student and household are at risk of severe outcome from COVID-19 infection. Evidence shows that both children and adults are at considerable risk from long COVID, and as such, both student and household wish to reduce exposure to COVID-19 which is currently endemic in communities, especially in indoor environments with higher numbers of people from multiple households gathering (See Resources Section). These risks can be reasonably mitigated by adding accommodations that will considerably reduce risks of infection (listed under Accommodations section).

Additional Information:

Using Section 504 Plan for Students and Households At Risk for COVID-19

To comply with their Federal non-discrimination obligations under Section 504, school districts must make reasonable modifications when necessary to ensure equal access for their students with disabilities, absent a showing that the modifications would constitute a fundamental alteration or undue administrative burden to the program.

In addition, if a parent or other member of the IEP or Section 504 team believes that particular COVID-19 prevention strategies are necessary for the provision of FAPE (Free Appropriate Public Education) to the student, the team must consider whether, and to what extent, such measures are necessary, based on student-specific information.” [2]

- A. According to major health organizations, the Section 504 Plan is an appropriate tool to use to provide equal access to education for students and households who are at risk for serious outcomes from COVID-19 infection.
- B. In the **CDC’s** [“Operational Guidance for K-12 Schools and Early Care and Education Programs to Support Safe In-Person Learning”](#), and [Preventing Spread of Infections in K-12 Schools](#), [1] they indicate that schools must make reasonable modifications or accommodations when necessary to ensure that all students are able to access in-person learning.
 - They indicate one of the tools parents and schools can use as a **Section 504 plan**, protected under federal and state disability laws, that require an **individualized approach** for working with children and youth.
 - The CDC states “Schools and ECE programs should also **consider the needs of people who are at risk for getting very sick with COVID-19 or who have family members at risk for getting very sick with COVID-19**. Some students and staff may need additional protections to ensure they can remain safely in the classroom.”
 - A [“Letter to Educators and Parents Regarding New CDC Recommendations and their Impact on Children with Disabilities”](#) written by the Secretary of Education, Miguel A. Cardona, Ed.D, states: **“Schools must continue to take action to preserve safe in-person learning opportunities for students with disabilities, including those at high risk of severe outcomes from COVID-19.”**

1. Section 504 Plan

- a. Section 504 of the Rehabilitation Act of 1973 **prohibits discrimination** based on disability in any program or activity that receives funding from the federal government. State public schools must comply with this federal law, which requires public schools to provide a **"free appropriate public education"** (FAPE) to every student with a disability—regardless of the nature or severity of the disability. Under Section 504, schools must provide students with disabilities the **accommodations, aids, and services they need to access and benefit from education equally with their peers**. [3]

2. Disability under Section 504

- a. Eligibility Under Section 504: Under Section 504, a person has a disability if they: (1) have a physical or mental impairment that substantially limits a major life activity; (2) have a record of such an impairment; or (3) are regarded as having such an impairment.
- b. Major life activities include, for example, breathing and concentrating as well as major bodily functions such as functions of the immune system. A student does not need to be substantially limited in their learning to be eligible for protection and services under Section 504. If a student is substantially limited in one or more major life activities, the student would have a disability under Section 504. This analysis applies to all students, whether in pre-school, elementary or secondary school, or a postsecondary setting. [4]
- c. Section 504 defines disability as a physical or mental impairment which substantially limits one or more major life activities. This definition of disability should be interpreted broadly. [5]

Parental Statement:

COVID-19 Infection puts the student and/or household at significant risk to all of the major life activities, **see resources section**. Putting the child in a building without the below mitigations constitutes an environment for the child that is not conducive to learning, and the child cannot concentrate on learning and completing assignments knowing they and/or their households are at significant risk to their health when put in such a setting without the following COVID-19 risk mitigation accommodations, **see accommodations section**.

3. Parents' Rights Under 504

Parents Have Rights Under Section 504. The school must give parents a copy of their rights, called Procedural Safeguards, before anyone takes the first step toward evaluating a student or developing a 504 plan.

I, _____, am exercising my following rights as a parent:

A. I, _____, parent of _____ request a 504 Plan Evaluation for accommodations for the purposes of mitigating COVID-19 Risks

- a. Anyone, including a parent or guardian, can refer a student for evaluation. A Section 504 referral should be in writing and ask that the school evaluate whether or not a student has a disability and needs accommodations, aids, and services. Schools have a special responsibility to make a Section 504 referral for every student they know or suspect may need accommodations, aids, or services.

B. School Brings a 504 Team Together: The individual needs of the student determine who joins the 504 team. There are three core members of any 504 team:

- a. Someone who knows the student's situation—for example, a parent
- b. Someone who can analyze and interpret the evaluation.
- c. Someone who is knowledgeable about options at the school.

C. Evaluation by 504 Team

- a. The 504 team will determine if a student is eligible and will decide what accommodations, aids, or services should be in place to reduce or eliminate the impact of the student's disability on his or her education
- b. A school cannot require a parent to provide a medical diagnosis to evaluate a student. However, a diagnosis can provide very helpful information for the 504 team. [5]
- c. The Section 504 regulations require school districts to draw upon a variety of sources in interpreting evaluation data and making placement decisions [6].

Formal Complaints — Discrimination and Discriminatory Harassment

If you believe the school is not following your child's Section 504 plan or your child is experiencing discrimination or harassment, you can file a formal complaint.

Contact the U.S. Department of Education, Office for Civil Rights at 206-607-1600 (TDD: 1-800-877-8339), or visit the website, www.ed.gov/ocr

Resources Section:

COVID-19 infection puts the child and household at significant health risk, but can be managed by COVID-19 risk mitigation accommodations.

1. **The World Health Organization (WHO) and Centers for Disease Control and Prevention (CDC)** acknowledge the elevated risks of aerosol transmission of SARS-CoV-2 in poorly ventilated and/or crowded indoor settings, where people tend to spend longer periods of time.
2. In response, international health organizations such as [WHO](#), [CDC](#), [ASHRAE](#), the US [EPA](#), [WHN](#), the Federal Public Service ([FPS](#)) Health, Food Chain Safety and Environment of Belgium; and several independent teams of scientists have suggested guidelines and frameworks for infection control strategies **using ventilation, air filtration, and air disinfection in indoor environments [11]**. These suggestions are not particular to the COVID-19 pandemic, and following them could also reduce exposures to other infectious aerosols, as well as some indoor air pollutants such as particulate matter (PM), allergens, and VOCs.
3. CDC's "Operational Guidance for K-12 Schools and Early Care and Education Programs to Support Safe In-Person Learning, Strategies for Everyday Operations" states, "Schools and ECE programs should take a variety of actions every day to prevent the spread of infectious diseases, including the virus that causes COVID-19. The following set of strategies for everyday operations should be in place at all COVID-19 Community Levels, including low levels:
 - a. **Taking steps to increase outdoor air intake and improve air filtration**, such as safely opening windows and doors, including on school buses and ECE transportation vehicles, and **using portable air cleaners with HEPA filters to improve ventilation and filtration**. Schools and ECE programs may also consider holding some activities outside.
 - b. Wearing a well-fitting mask or respirator consistently and correctly reduces the risk of spreading the virus that causes COVID-19. **Anyone who chooses to wear a mask or respirator should be supported in their decision to do so at any COVID-19 Community Level, including low.**
 - c. Washing hands can prevent the spread of infectious diseases. Schools and ECE programs should teach and reinforce proper handwashing to reduce the risk of spreading viruses, and should also **provide adequate handwashing**

supplies, including soap, water and paper towels. If washing hands is not possible, schools and ECE programs should provide hand sanitizer containing at least 60% alcohol. Schools and ECE programs should **teach and reinforce covering coughs and sneezes** to help keep individuals from getting and spreading infectious diseases, including COVID-19.

- d. Schools should **provide excused absences for students who are sick, avoid policies that incentivize coming to school while sick, and support children who are learning at home if they are sick.** Schools and ECE programs should ensure that employees and families are aware of and understand these policies and avoid language that penalizes or stigmatizes staying home when sick."

Accommodations Section:

1. My child/household is at risk for serious adverse health outcomes if infected with COVID-19.
 - a. My child is at serious risk (1 in 4 risk) of developing long-Covid if infected with COVID-19 [7].
 - b. Repeat infections increase this risk including the chances of organ failure and death [8].
 - c. Even mild respiratory infections of SARS-CoV-2 could lead to neuroinflammation and subsequent brain damage [9].
 - d. COVID-19 infection, especially with Omicron strains, has been shown to be significantly more lethal to children and adolescents than the flu [10].
 - e. A member of our household has one or more medical conditions that make him/her/them higher risk for severe outcome from COVID-19. Since [COVID-19 has a high risk of spreading from children attending school to household](#), the household requires child to have reasonable accommodations in order to prevent infection.

2. The following **significantly reduce the risk of COVID-19 infection**, including
 - a. improving ventilation and filtration (8-12 air changes per hour (ACH), leaning towards 12 when 6 feet distance/reduced capacity cannot be obtained) which can be obtained by the use of HEPA purifiers, fan-and-filter air cleaners that use MERV-13 or higher filters (such as DIY CR Boxes, and commercial fan-and-filter boxes), and improving ventilation by means such as safely opening windows. The number/ combination of ventilation and filtration units required to reach the 8-12 ACH [11] for the indoor space can be determined with the following tools:
 - i. Allow the child/teacher use of a CO2 monitor (such as an Aranet) to measure ventilation of space. Allow the teacher to open windows to keep the room below 1000 ppm, and have the child avoid indoor environments that are above recommended 1000 ppm and/or provide alternative environments, and/or contact parent/caretaker to pick up the child.

- ii. Use of air filtration devices in the child's educational space at the correct type and number of units for the child's space in order to achieve 8-12 ACH.
 1. **Circle one:** (Parent or school) must provide units. The following tools will be helpful in determining the number and type of units required for the space:
 2. Input the room size with a target of at least 8 ACH (if HVAC in classroom you can put a starting value of 2 ACH) in the The URM C Rochester Tool:
<https://www.urmc.rochester.edu/dentistry/research/air-ventilation/CADR-calculation.html>
 3. or the Use the Ventilation Calculation Tool:
<https://www.ohcow.on.ca/covid-19/ventilation-calculation-tool/#1636724707161-69ae9142-2a76> to determining the combined Clean Air Delivery Rate (CADR) needed for more specific situations.
- b. Allow and support the child in wearing his/her/their mask. Notify the parent if child does not wear a mask when indoors by calling them immediately to pick up the child from school. Allow the child to wear a lanyard with extra masks to change into if the child's mask is soiled or breaks, and allow the child to carry sanitizer. Allow child access to hand-washing and tissues. Allow this child outdoor distanced (at least 6 feet from others) breaks when he/she/they requests them.
- c. At times when a child cannot wear a mask (i.e. while eating lunch) arrange for additional mitigations to lower risk, such as eating outdoors, or having a private indoor eating area in the classroom or space that is set up with the 6-12 ACH, along with whoever is supervising him to be wearing a mask while he has his off. If this is not possible, allow his parent/ approved caretaker to pick him up during lunch to eat off campus.

Accommodations Checklist for teachers:

- ☐ **Allow the student to wear their mask**, carry extra masks, hand sanitizer, and/or personal air purifier during school.
- ☐ **Allow fan-and-filter CR-BOX (may be provided by parent or school) [13] and HEPA Purifier (provided by parent or school) to run in the child's classroom, in order to achieve the recommended 8-12 air changes per hour (ACH), leaning toward 12 ACH.**
- ☐ **Allow CO2 monitor** in the classroom, keep CO2 at below 1000 ppm by having teachers open windows to air out classroom when in warning range. If windows cannot be opened to reduce CO2 concentration, call parent who will pick the child up, and arrange virtual options.
- ☐ Allow the student to have **preferential seating** in the classroom (sitting near CR-BOX [13], HEPA, or near open windows)
- ☐ If the school is experiencing a high **absentee rate (5 percent for one day or 3 to 4 percent for two or more days) [14], or if the child's class has an absentee rate of 10% or higher**, parent of the child will be **notified by email**.
- ☐ Allow the student to **use the school library as a study center** during high class absenteeism, **and/or to make up work at home virtually if not attending in-person due to high rates of COVID or high absentee rates**.
- ☐ Allow the student to be **picked up by parent or approved caretaker during lunch hours** to allow off campus eating.
- ☐ **Adapt in-person attendance policies** and length of school days if needed for the student and their COVID-19 risk mitigation plan, and allow student alternative ways to keep up with lessons such as allowing them to **record teacher lectures/lessons to watch at home, and turn in assignments via email**.
- ☐ Develop a **"missed class work plan" for absences**, arrange for virtual one-to-one help for new concepts that were missed, and provide adequate time for makeup work to be handed in.
- ☐ Teacher communicates with the school nurse/parent regarding **trips/outings/assemblies** for COVID-19 risk mitigation plan and if/when appropriate, offers virtual options as substitutions.
- ☐ Ensure that every appropriate staff member knows the health care plan for the student (teachers, nurse, admin for lunch pickup/drop offs, admin for email notification of high absenteeism in school).

- ☐ Place the student in easily controlled areas and environments for maximum engagement and involvement (areas with CR-Boxes, increased ventilation, ability to space out).
- ☐ Provide alternatives to high risk activities such as singing, shouting, blowing into instruments, or close vicinity sports/exercising, or allow students to be excused to the library or other study area.

Parent/ Emergency Contact Information:

Full Name/ Relationship:

Email:

Phone (voice/texting/voicemail):

Emergency Contacts/ Approved Caretakers:

1.

2.

3.

Notes:

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Preventing Spread of Infections in K-12 Schools

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syndrome ORs Odds ratios PCS Prospective cohort study PRISMA Preferred Items for Systematic Reviews and Meta-analyses RCS Retrospective cohort study rt-PCR Real-time reverse transcription-polymerase chain reaction. Published online 123AD.

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Attachments For more information:

A. Infection Control Policies Reduce Illness and Absences

Recommended Actions:

COVID-19 risks are a current problem and they do require managed actions to reduce hazards:

Figure 1: Infection Control Policies Work

Infection Control Policies Work		
Symptom Screen, Encourage Testing and Proper Isolation	Improve Indoor Air Quality	Encourage and Provide Respirator Masks

Nearly half of COVID-19 transmissions can be prevented by sending symptomatic individuals home, or at the very least requiring them to mask. Update COVID-19 isolation guidance to 10- day minimum (with preferred 14 days) Provide Tests To reduce asymptomatic and presymptomatic spread, encourage testing for exposures in home or at school, symptoms. Testing and isolation reduces transmission in schools. *Doesn't protect from pre symptomatic or asymptomatic transmission or false negatives on tests.	Set ventilation standards in classrooms to under 800 ppm CO2 (or under 1000 ppm with added filtration) [NEA][CDC] Add MERV-13 filters into HVAC units. Supplement with HEPA purifiers and/or MERV-13 fan-filter boxes 8-12 Air Changes per Hour (ACH) reduces infections by 65-80% by reducing build up of virus indoors. Provide distanced outdoor eating accommodations. *Doesn't protect from close-range transmission for any of the types of spread (needs to be combined with mask-wearing)	Provide N95 equivalent, or superior respirator masks (KF94, KN95 come in child sizes); (surgical masks which do not provide adequate protection for aerosols should only be used if n95 or equivalents are not available) Respirator masks can reduce infections up to 95% for wearers Reduces close-range transmission better than other precautions, especially when two-way. *other measures such as air filtration, reducing number of sick people in space should also be implemented.
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The three types of spread—presymptomatic, asymptomatic, and symptomatic— can be mitigated.

Eliminate symptomatic spread by using proper testing and isolation policies that will reduce COVID-19 transmissions by reducing the number of COVID-positive cases coming into the space.

Update Infection Control Policies:

- **Update attendance policy** by sending symptomatic individuals home with a testing requirement (2 tests over the course of 3 days). Update COVID-19 [isolation guidance to minimum 10 days \(14 days preferred\) home for known positives](#), with longer isolation periods if necessary due to continued positivity on Rapid Antigen Tests (RATs), continued symptoms, and/or considering medical history (i.e. [immunosuppressed individuals are contagious longer and are recommended longer isolation times, and may be infectious for many weeks](#), and may thus be prescribed by their doctors to stay home longer and should not be penalized for doing so).
 - In a 2022 omicron study, [most people still test positive on RATs past 5 days](#), and up to 10-12 days.

- In a [2023 study](#) a significant amount of infectious virus was detected in the exhaled breath of COVID-positive people for 8 days regardless of vaccination status, and including asymptomatic and mild cases.
- Current attendance and sick policies in the facility are not adequate even to [minimum isolation standards from the CDC](#), which for COVID-19 requires symptoms to be improving and 5 days of masking afterwards. Because the school and/or workplace is unable to enforce testing or masking, nor prevent contact from those at higher risks, a minimum of 10 days, with a [preferred minimum 14 day isolation period](#), should be recommended for infection control for COVID-19.
- **Emphasize mask-wearing and enhanced air cleaning are core strategies and put the highest level of policies in place to support their implementation.**
 - According to a [CDC report](#), COVID-19 incidence was **37% lower** in schools that required teachers and staff members to use masks and **39% lower** in schools that improved ventilation. Ventilation strategies associated with lower school incidence included dilution methods alone (35% lower incidence) or in combination with filtration methods (**48% lower** incidence).
 - A [2023 study](#) showed two DIY air cleaners **reduced aerosol exposure up to 73%**.
 - A [2022 study](#) showed schools with mask mandates had significantly less COVID-19 infections than those that stopped.
 - A [2021 study](#) showed universal masking is much more effective than one-way masking, with the more people masking the greater the benefit.
 - [Masks are recommended by CDC](#) for adults and for children ages 2 and up to wear to help keep them healthy and prevent the spread of infections.
 - **Improve Indoor Air Quality** to under 800 ppm CO₂. Carbon Dioxide (CO₂) is used as a proxy for inadequate ventilation in buildings, with monitoring to achieve the [800ppm recommended by the CDC for infection control](#), or [1,000ppm if filtration measures of 8-12 ACH are implemented](#). **Supplement with HEPA purifiers and/or DIY fan-filter boxes** to get the [6-12 Air Changes per Hour \(ACH\)](#), or appropriate CFM per person for infection control which equates to 8-12 ACH [[ASHRAE Standard 241](#)], which can reduce infections by [65-80%](#) by reducing build up of virus indoors.

Enhance Air Quality:

Improve indoor air quality and provide masks to help to **prevent asymptomatic and presymptomatic spread**. Air filtering takes time to begin to work and clear out infectious aerosols, and masks work better at lower densities, so both of these methods are more efficacious when used together on top of policies that reduce the amount of virus coming into a space.

When transmission is reduced, both illness and absences are reduced, and students, staff, and their households will remain healthier. Management needs to take action today to put these infection risk policies into action.

B. Preventing Spread of Infections in K-12 Schools (CDC):

Schools provide safe, supportive environments, routines, and important services that support student health and well-being. Schools should have plans in place that can help reduce illness and illness-related absenteeism by preventing the spread of common infections. This guidance is designed to maximize school attendance and its benefits for all students, while also preventing the spread of infectious diseases.

- Schools can help prevent infections caused by common childhood respiratory or stomach viruses by using and encouraging everyday actions.
- If illnesses are spreading in the community, additional actions can be taken by schools to prevent infections from spreading.
- Schools can prepare for outbreaks or a pandemic by ensuring that they have an [emergency operations plan with an infectious disease section](#)
- , which outlines the actions necessary to reduce the impact of the outbreak.

This new guidance consolidates and simplifies previous recommendations intended specifically for K-12 school settings. It replaces previous guidance that was for COVID-19 and influenza in schools, is aligned with [CDC's respiratory virus guidance](#), and is based on scientific studies that showed what works best to prevent the spread of many common respiratory and stomach infections. These strategies can also reduce the spread of many other infectious diseases in schools.

Science Brief

Prevention and Control of Respiratory and Gastrointestinal Infections in Kindergarten through Grade 12 (K-12) Schools

On CDC's website, there is additional guidance for several other illnesses (e.g., [strep throat](#), [hand-foot-mouth disease](#), [norovirus](#), [head lice](#), [pink eye](#), [impetigo](#), [scabies](#), [measles](#), and [molluscum contagiosum](#)) that schools can use to prevent specific infections. Information on [diseases from mosquitos](#) (e.g., West Nile Virus, dengue) is also available.

Schools should work with their local public health partners, and engage parents/caregivers and other community partners, to create their emergency operations plan that includes a section on infectious diseases. School and public health officials can promote learning and health for all students and staff by implementing comprehensive prevention strategies to keep students, staff, families, and school communities healthy and provide supportive environments for in-person learning. [Federal civil rights laws](#) may require that schools provide [reasonable modifications or accommodations](#) in various circumstances.

Schools must provide reasonable modifications or reasonable accommodations, when necessary, to ensure equal access to in-person learning for students with disabilities during increased infectious illness activity. Nothing in this guidance is intended to detract from or supersede those laws.

This guidance also highlights the importance of clear and consistent communication between school administrators, parents and caregivers, and staff. Providing clear and accessible communication to families and staff is required for the success of many strategies described in this guidance. Communication strategies should consider the needs of people with limited English proficiency who require language services, and [individuals with disabilities who require accessible formats](#).



Last Reviewed: May 17, 2024

C.Operational Guidance for K-12 Schools and Early Care and Education Programs to Support Safe In-Person Learning

Updated Oct. 4, 2023

[Español](#) | [Other Languages](#)

[Print](#)

Summary of Recent Changes

Updated COVID-19 testing language in coordination with updates to [COVID-19 Testing: What You Need to Know](#)

Replaces COVID-19 Community Levels with COVID-19 hospital admission levels to guide prevention decisions. See the following for details on the reasons for this change.

MMWR: [COVID-19 Surveillance After Expiration of the Public Health Emergency Declaration — United States, May 11, 2023](#)

MMWR: [Correlations and Timeliness of COVID-19 Surveillance Data Sources and Indicators — United States, October 1, 2020–March 22, 2023](#)

Introduction

Schools and early care and education (ECE) programs are an important part of the infrastructure of communities as they provide safe, supportive learning environments for students and children and enable parents and caregivers to be at work. Schools and ECE programs like Head Start also provide critical services that help to mitigate health disparities, such as school lunch programs, and social, physical, behavioral, and mental health services. This guidance can help K-12 schools and ECE programs remain open and help their administrators

support safe, in-person learning while reducing the spread of COVID-19. Based on COVID-19 hospital admission levels, this guidance provides flexibility so schools and ECE programs can adapt to changing local situations, including periods of increased community health impacts from COVID-19.

K-12 schools and ECE programs (e.g., center-based child care, family child care, Head Start, or other early learning, early intervention and preschool/pre-kindergarten programs delivered in schools, homes, or other settings) should put in place a core set of infectious disease prevention strategies as part of their normal operations. The addition and layering of COVID-19-specific prevention strategies should be tied to the COVID-19 hospital admission levels and community or setting-specific context, such as availability of resources, health status of students, and age of population served. Enhanced prevention strategies also may be necessary in response to an outbreak in the K-12 or ECE setting. This CDC guidance is meant to supplement—not replace—any federal, state, tribal, local, or territorial health and safety laws, rules, and regulations with which schools and ECE programs must comply.

Schools and ECE programs play critical roles in promoting equity in learning and health, particularly for groups disproportionately affected by COVID-19. People living in rural areas, people with disabilities, immigrants, and people who identify as American Indian/Alaska Native, Black or African American, and Hispanic or Latino have been disproportionately affected by COVID-19. These disparities have also emerged among children. School and ECE administrators and public health officials can promote equity in learning and health by demonstrating to families, teachers, and staff that comprehensive prevention strategies are in place to keep students, staff, families, and school communities safe and provide supportive environments for in-person learning. Reasonable modifications or accommodations, when necessary, must be provided to ensure equal access to in-person learning for students with disabilities.

Though this guidance is written for COVID-19 prevention, many of the layered prevention strategies described in this guidance can help prevent the spread of

other infectious diseases, such as influenza (flu), respiratory syncytial virus (RSV), and norovirus, and support healthy learning environments for all. The next section describes everyday preventive actions that schools and ECE programs can take.

Strategies for Everyday Operations

Schools and ECE programs should take a variety of actions every day to prevent the spread of infectious diseases, including the virus that causes COVID-19. The following set of strategies for everyday operations should be in place at all COVID-19 hospital admission levels, including low levels.

Staying Up to Date on Vaccinations

Schools, ECE programs, and health departments should promote equitable access to vaccination. Staying up to date on routine vaccinations is essential to prevent illness from many different infections. COVID-19 vaccination helps protect eligible people from getting severely ill with COVID-19. For COVID-19, [staying up to date with COVID-19 vaccinations](#) is the leading public health strategy to prevent severe disease. Not only does it provide individual-level protection, but high vaccination coverage reduces the burden of COVID-19 on people, schools, healthcare systems, and communities. Schools, ECE programs, and health departments can promote vaccination in many ways:

- Provide information about [COVID-19 vaccines](#) and other recommended vaccines. Ensure communication meets the needs of people with limited English proficiency who require language services and individuals with disabilities who require accessible formats.

- Encourage trust and confidence in COVID-19 vaccines.

- Establish supportive policies and practices that make getting vaccinated easy and convenient, for example [a workplace vaccination program](#) or

providing paid time off for individuals to get vaccinated or assist family members receiving vaccinations.

Make vaccinations available on-site by hosting school-located vaccination clinics, or connect eligible children, students, teachers, staff, and families to off-site vaccination locations.

Staying Home When Sick

People who have symptoms of respiratory or gastrointestinal infections, such as cough, fever, sore throat, vomiting, or diarrhea, should stay home. Testing is recommended for people with symptoms of COVID-19 as soon as possible after symptoms begin. If a person with COVID-19 symptoms tests negative for COVID-19, they should consider getting tested for other respiratory illnesses that could be spread to others, such as flu. If tested using an antigen test, negative tests should be repeated following FDA recommendations

. People who are at risk for getting very sick with COVID-19 who test positive should consult with a healthcare provider right away for possible treatment, even if their symptoms are mild. Staying home when sick can lower the risk of spreading infectious diseases, including COVID-19, to other people. For more information on staying home when sick with COVID-19, including recommendations for isolation and mask use for people who test positive or who are experiencing symptoms consistent with COVID-19, see Isolation and Precautions for People with COVID-19.

In accordance with applicable laws and regulations, schools and ECE programs should allow flexible, non-punitive, and supportive paid sick leave policies and practices. These policies should support workers caring for a sick family member and encourage sick workers to stay home without fear of retaliation, loss of pay, loss of employment, or other negative impacts. Schools should also provide excused absences for students who are sick, avoid policies that incentivize coming to school while sick, and support children who are learning at home if they are sick. Schools and ECE programs should ensure that employees and

families are aware of and understand these policies and avoid language that penalizes or stigmatizes staying home when sick.

ECE Programs: Prevention and Control of Infectious Diseases

Ventilation

Schools and ECE programs can optimize [ventilation](#) and maintain improvements to indoor air quality to reduce the risk of germs and contaminants spreading through the air. Funds provided through the U.S. Department of Education's [Elementary and Secondary Schools Emergency Relief \(ESSER\) Programs](#)

and the [Governor's Emergency Education Relief \(GEER\) Programs](#)

and the Department of Health and Humans Services' [Head Start and Child Care American Rescue Plan](#)

can support improvements to [ventilation](#); repairs, upgrades, and replacements in Heating, Ventilation, and Air Conditioning (HVAC) systems; purchase of MERV-13 air filters, portable air cleaners, and [upper-room germicidal ultraviolet irradiation systems](#); as well as implementation of other public health protocols and CDC guidance. The Environmental Protection Agency's (EPA) [Clean Air in Buildings Challenge](#)

[107 KB, 3 pages]

provides specific steps schools and other buildings can take to improve indoor air quality and reduce the risk of airborne spread of viruses and other contaminants. Ventilation recommendations for [different types of buildings](#) can be found in the [American Society of Heating, Refrigerating, and Air-Conditioning Engineers \(ASHRAE\) schools and universities guidance](#)

[1.9 MB, 41 pages]

. CDC does not provide recommendations for, or against, any manufacturer or product.

When COVID-19 hospital admission levels increase or in response to an outbreak, schools and ECE programs can take [additional steps](#) to increase outdoor air intake and improve air filtration. For example, safely opening windows and doors, including on school buses and ECE transportation vehicles, and using portable air cleaners with HEPA filters, are strategies to improve ventilation. Schools and ECE programs may also consider holding some activities outside if feasible when the COVID-19 hospital admission level is high.

Hand Hygiene and Respiratory Etiquette

Washing hands can prevent the spread of infectious diseases. Schools and ECE programs should teach and reinforce proper handwashing to lower the risk of spreading viruses, including the virus that causes COVID-19. Schools and ECE programs should monitor and reinforce these behaviors, especially during key times in the day (for example, before and after eating, after using the restroom, and after recess) and should also provide adequate handwashing supplies, including soap and water. If washing hands is not possible, schools and ECE programs should provide hand sanitizer containing at least 60% alcohol. Hand sanitizers should be stored up, away, and out of sight of younger children and should be used only with adult supervision for children ages 5 years and younger.

Schools and ECE programs should teach and reinforce covering coughs and sneezes to help keep individuals from getting and spreading infectious diseases, including COVID-19.

Cleaning

Schools and ECE programs should clean surfaces at least once a day to reduce the risk of germs spreading by touching surfaces. For more information, see Cleaning and Disinfecting Your Facility. Additionally, ECE programs should follow recommended procedures for cleaning, sanitizing, and disinfection in their setting such as after diapering, feeding, and exposure to bodily fluids. See [Caring for Our Children](#)

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COVID-19 Hospital Admission Levels and Associated Prevention Strategies

CDC's COVID-19 hospital admission levels help communities and individuals make decisions about what COVID-19 prevention strategies to use based on whether their community is classified as low, medium, or high. These levels take into account COVID-19 hospitalization admission rates. Recommendations outlined for the COVID-19 hospital admission levels are the same for schools and ECE programs as those for the community. Schools and ECE programs that serve students from multiple communities should follow prevention recommendations based on the COVID-19 hospital admission level of the community in which the school or ECE program is located.

School and ECE program administrators should work with local health officials to consider other local conditions and factors when deciding to implement prevention strategies. School and ECE-specific indicators—such as rates of absenteeism among students and staff or presence of students or staff who are at risk of getting very sick with COVID-19—can help with decision-making. Additional community-level indicators that might be considered for use in decision-making about COVID-19 prevention are pediatric hospitalizations, results from [wastewater surveillance](#), or other local information.

When the COVID-19 hospital admission level indicates an increase, particularly if the level is high or the school or ECE program is experiencing an outbreak, schools or ECE programs should consider adding layered prevention strategies, described below, to maintain safe, in-person learning and keep ECE programs safely open. Although most strategies are recommended to be added or increased at a high COVID-19 hospital admission level, schools might want to consider adding layers when at medium, such as those in the [Considerations for](#)

Prioritizing Strategies section below, based on school and community characteristics.

When the COVID-19 hospital admission level moves to a lower category or after resolution of an outbreak, schools and ECE programs can consider removing prevention strategies one at a time, followed by close monitoring of COVID-19 transmission within the school or ECE and the COVID-19 hospital admission level of their community in the weeks that follow.

Masking

Wearing a [well-fitting mask](#) or respirator consistently and correctly reduces the [risk of spreading the virus](#) that causes COVID-19. At a high COVID-19 hospital admission level, universal indoor masking in schools and ECE programs is recommended, as it is in the community at-large. Policies for use of masks in school nurse offices should follow recommendations outlined in the [Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\)](#) guidance. Recommendations for masking in nurses' offices may depend on factors such as COVID-19 hospital admission level, outbreak status, and patient access. People who have known or suspected exposure to COVID-19 should also wear a well-fitting mask or respirator around others for 10 days from their last exposure, regardless of vaccination status or history of prior infection.

Anyone who chooses to wear a mask or respirator should be supported in their decision to do so at any COVID-19 hospital admission level, including low. At a medium and high COVID-19 hospital admission level, people who are immunocompromised or at risk for getting very sick with COVID-19 should wear a mask or respirator that provides greater protection. Since wearing masks or respirators can prevent spread of COVID-19, people who have a household or social contact with someone at risk for getting very sick with COVID-19 (for example, a student with a sibling who is at risk) may also choose to wear a mask at any COVID-19 hospital admission level. Schools and ECE programs should

consider flexible, non-punitive policies and practices to support individuals who choose to wear masks regardless of the COVID-19 hospital admission level.

Schools with students at risk for getting very sick with COVID-19 must make reasonable modifications or accommodations when necessary to ensure that all students, including [those with disabilities](#), are able to access in-person learning. Schools might need to require masking in settings such as classrooms or during activities to protect students with immunocompromising conditions or other conditions that increase their risk for getting very sick with COVID-19 in accordance with applicable federal, state, or local laws and policies. For more information and support, visit the [U.S. Department of Education's Disability Rights](#) webpage. Students with immunocompromising conditions or other conditions or disabilities that increase risk for getting very sick with COVID-19 should not be placed into separate classrooms or otherwise segregated from other students.

Because mask use is not recommended for children ages younger than 2 years and may be difficult for very young children or for some [children with disabilities who cannot safely wear a mask](#), ECE programs and K-12 schools may need to consider other prevention strategies—such as improving ventilation and avoiding crowding—when the COVID-19 hospital admission level is medium or high or in response to an outbreak. K-12 schools or ECE programs may choose to implement universal indoor mask use to meet the needs of the families they serve, which could include people at risk for getting very sick with COVID-19.

For more information about masks please visit [Types of Masks and Respirators](#).

Testing

Diagnostic Testing

Schools and ECE programs can offer [diagnostic testing](#) for students and staff with symptoms of COVID-19 or who were exposed to someone with COVID-19 in the K-12 or ECE setting, or refer them to a community testing site, healthcare

provider, or to use an at-home test. Each COVID-19 test with an [emergency use authorization \(EUA\)](#) has a minimum age requirement. Schools and ECE programs should only use tests that are appropriate for the person being tested. For more information on when someone should test, where to get tests, and what results mean, please visit [COVID-19 Testing: What You Need to Know](#).

Screening Testing

Screening testing identifies people with COVID-19 who do not have symptoms or known or suspected exposures, so that steps can be taken to prevent further spread of COVID-19.

CDC no longer recommends routine screening testing in K-12 schools. However, at a high COVID-19 hospital admission level, K-12 schools and ECE programs can consider implementing screening testing for students and staff for high-risk activities (for example, close contact sports, band, choir, theater); at key times in the year, for example before/after large events (such as prom, tournaments, group travel); and when returning from breaks (such as holidays, spring break, at the beginning of the school year). In any screening testing program, testing should include both vaccinated and unvaccinated people. Schools serving students who are at risk for getting very sick with COVID-19, such as those with moderate or severe immunocompromise or complex medical conditions, can consider implementing screening testing at a medium or high COVID-19 hospital admission level. [Nucleic acid amplification tests](#) (NAATs) and [antigen](#) tests can be used for screening purposes; however, the school should consider the [characteristics of different test types](#) (including accessibility, accuracy and practicality) to determine which best suits their particular need. Schools and ECE programs that choose to rely on at-home antigen test kits for screening testing should ensure equal access and availability to the tests; establish accessible systems that are in place for ensuring timely reporting of positive results to the school or ECE program; and communicate with families the importance of following [isolation guidance](#) for anyone who tests positive. Communication strategies should take into account the needs of people with limited English

proficiency who require language services, and individuals with disabilities who require accessible formats.

Screening testing should be done in a way that ensures the ability to maintain confidentiality of results and protect privacy. Consistent with state legal requirements and [Family Educational Rights and Privacy Act \(FERPA\)](#), K-12 schools and ECE programs should obtain parental consent for minor students and assent/consent from students themselves, when applicable.

Management of Cases and Exposures

Students or staff who come to school or an ECE program with [symptoms](#) or develop symptoms while at school or an ECE program should be asked to wear a well-fitting mask or respirator while in the building and be sent home and encouraged to get tested if testing is unavailable at school. Symptomatic people who cannot wear a mask should be separated from others as much as possible; children should be supervised by a designated caregiver who is wearing a well-fitting mask or respirator until they leave school grounds.

Schools and ECEs should develop mechanisms to ensure that people with COVID-19 [isolate](#) away from others and do not attend school until they have completed isolation. Once isolation has ended, people should wear a well-fitting mask or respirator around others through day 10. Testing is not required to determine the end of isolation or mask use after having COVID-19; however people can use the test-based strategy outlined in the [isolation guidance](#) to potentially shorten the duration of post-isolation mask use. If using the test-based strategy, people should continue to wear a well-fitting mask or respirator in the school or ECE setting until testing criteria have been met. People who are not able to wear a well-fitting mask or respirator should either isolate for 10 full days or follow the test-based strategy to determine when they can safely return to the school or ECE setting without a mask, while continuing to isolate until testing criteria have been met. If a person with COVID-19 has been inside a school or ECE facility within the last 24 hours, the space should be

cleaned and disinfected. For more information, see [Cleaning and Disinfecting Your Facility](#).

Quarantine is no longer recommended for people who are exposed to COVID-19 except in certain high-risk congregate settings such as correctional facilities, homeless shelters, and nursing homes. In schools and ECE settings, which are generally not considered high-risk congregate settings, people who were exposed to COVID-19 should follow [recommendations](#) to wear a well-fitting mask and get tested. K-12 school and ECE administrators can decide how to manage exposures based on the local context and benefits of preserving access to in-person learning. Accommodations may be necessary for exposed people who cannot wear a mask or have difficulty wearing a well-fitting mask. Schools and ECE programs can also consider recommending masking and/or testing for a classroom in which a student was recently exposed who is unable to consistently and correctly wear a mask.

Quarantine is a key component to Test to Stay programs. Since quarantine is no longer recommended for people who are exposed to COVID-19 except in certain high-risk congregate settings, Test to Stay (TTS) is no longer needed. If any school or ECE program chooses to continue requiring quarantine, they may also choose to continue TTS.

Responding to Outbreaks

If a school or ECE program is experiencing a COVID-19 [outbreak](#) they should consider adding prevention strategies regardless of the COVID-19 hospital admission level. Strategies that can help reduce transmission during an outbreak include wearing well-fitting masks or respirators, improving ventilation (for example moving school activities outdoors, opening windows and doors, using air filters), screening testing, and case investigation and contact tracing. Early identification of cases to ensure that they stay home and isolate is a critical component of outbreak response. Schools and ECE programs may also consider suspending high-risk activities to control a school- or program-associated

outbreak. Schools and ECE programs that are experiencing outbreaks should work with their state or local health department in accordance with state and local regulations. Health departments should provide timely outbreak response support to K-12 schools and ECEs.

Considerations for High-Risk Activities

Due to increased and forceful exhalation that occurs during physical activity, some sports can put players, coaches, trainers, and others at increased risk for getting and spreading the virus that causes COVID-19. Close contact sports and indoor sports are particularly risky for participants and spectators, especially in crowded, indoor venues. Similar risks may exist for other extracurricular activities, such as band, choir, theater, and other school clubs that meet indoors and entail increased exhalation. At a high COVID-19 hospital admission level, schools and ECE programs can consider implementing screening testing for high-risk activities such as indoor sports and extracurricular activities. Schools and ECE programs may consider temporarily stopping these activities to control a school- or program-associated outbreak, or during periods of high COVID-19 hospital admission levels. ECE programs may also consider layering prevention strategies, such as masking, when close contact occurs, such as during feeding and diapering young children and infants.

Considerations for K-12 Residential Dorms and Overnight Child Care

While shared housing, such as K-12 residential dorms, camps, or overnight child care, is considered a congregate setting, it is considered a low-risk congregate setting due to the lower risk of severe health outcomes (such as [hospitalizations](#) and [death](#)) for children and young adults. Therefore, CDC recommends shared housing facilities follow the general population guidance for [isolation](#), management of [exposures](#), and recommendations under COVID-19 hospital admission levels.

In specific circumstances where the student population may be at risk for getting very sick with COVID-19, schools may opt to follow isolation and quarantine

guidance for high-risk congregate settings, which includes recommendations of a 10-day period for isolation. Schools and ECE programs should balance the potential benefits of following that guidance with the impact these actions would have on student well-being, such as the ability to participate in in-person instruction, food service access, and social interactions. Screening testing at all COVID-19 hospital admission levels can also be appropriate in these settings to reduce transmission and improve health outcomes for people who are at risk of getting very sick with COVID-19.

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Considerations for Prioritizing Strategies

Schools and ECE programs, with help from local health departments, should consider local context when selecting strategies to prioritize for implementation. Schools and ECE programs should balance the risk of COVID-19 with educational, social, and mental health outcomes when deciding which prevention strategies to put in place. Additional factors to consider include:

Age of population served: Layered prevention strategies that are most suitable for young children should be given special consideration. Young children may have difficulty wearing a well-fitting mask consistently and correctly, and children ages under 2 years should not wear masks. For these reasons, layering additional prevention strategies—such as encouraging vaccination among staff and others around unvaccinated children, improved ventilation, and avoiding crowded spaces—should be used.

Students with disabilities: Federal and state disability laws require an individualized approach for working with children and youth with disabilities consistent with the child's individual educational plan (IEP), Section 504 plan, or Individualized Family Service Plan (IFSP). Reasonable modifications or accommodations, when necessary, must be provided to ensure equal access to in-person learning for students with disabilities.

Administrators should consider additional prevention strategies to accommodate the health and safety of students with disabilities and protect their civil rights and equal access to safe in-person learning. The U.S. Department of Education provides [guidance and resources](#) for schools and ECE programs to ensure students with disabilities continue to receive the services and supports they are entitled to so that they have successful in-person educational experiences.

People at risk of getting very sick: Schools and ECE programs should also consider the needs of [people who are at risk for getting very sick with COVID-19](#) or who have family members at risk for getting very sick with COVID-19. Some students and staff may need additional protections to ensure they can remain safely in the classroom. In addition, people who spend time indoors with individuals at risk for getting very sick with COVID-19 should consider taking extra precautions (for example, wearing a mask) even when the COVID-19 hospital admission level is not high. School districts, schools, ECE programs, and classrooms may choose to implement masking requirements at any COVID-19 hospital admission level depending on their community's needs – and especially keeping in mind those for whom these prevention strategies provide critical protection for in-person learning.

Equity: Equity at both the individual and school levels should be considered in all decision-making. Care should be taken so that decisions related to layered prevention strategies and learning options do not disproportionately affect any group of people. For instance, at the health department and school or ECE level, decisions to put in place strategies such as screening testing and contact tracing should be made in a way as to ensure that the same resources are provided to all within the district and community.

Availability of resources: Availability of resources, such as funding, personnel, or testing materials, vary by community. Schools or ECE programs may consider prioritizing strategies for responding to an

outbreak, or ramp strategies up as necessary. Alternatively, they may choose to focus resources on select, at-risk sites within the school or ECE program (such as recommending masking and testing for a classroom in which a student was recently diagnosed with COVID-19). Schools and ECE programs should work with local, state, and federal agencies to identify additional [resources](#)

[172 KB, 2 pages]

to implement strategies, including those provided to schools and ECE programs through the American Rescue Plan.

Communities served: The feasibility and acceptability of certain prevention strategies may vary within the community. Schools and ECE programs should consider community context and acceptability when choosing prevention strategies.

Pediatric-specific considerations: Schools and ECE programs should work closely with local health departments to stay updated on the latest science about COVID-19, its impact on the local healthcare and hospital system, and any changes to recommended prevention strategies. While children are at lower risk for getting very sick with COVID-19, some children may still be hospitalized as a result of the infection. When schools and ECE programs are considering increasing the use and number of prevention strategies when the COVID-19 hospital admission level is high, schools and ECE programs should take into account the extent to which students are at risk for getting very sick with COVID-19 or have family members [at risk for getting very sick](#) with COVID-19.