FCAAP Recommendations Regarding Schools During the COVID-19 Pandemic

November 23, 2020
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November 23, 2020 Addendum

Most areas of our country and Europe are seeing significant increases in the numbers of infections as the fall season progresses. The American Academy of Pediatrics recently reported that nationally, children make up 10% of COVID-19 infections, up from 2% in April. Admittedly, much of the increase is related to the fact that there was less testing of children in April. But as of November 19, 2020, there have been more than 1,200,000 pediatric infections reported in the USA, according to the American Academy of Pediatrics (AAP) and the Children’s Hospital Association.¹ Schools in several states, including New York, have been shut down again because of widespread infection with SARS-CoV-2. The FCAAP fears that Florida, soon, will see the same significant increases in infection as other parts of the country have recently seen.

The following updates have been made to the paper since the update of October 20, 2020²:

1. Update on infection rate in Florida (Pages 2-3).
2. Recommendation 11 regarding sports (Pages 11-12).
3. Recommendation 13 regarding change in CDC definition of how to calculate 15 minutes of contact (page 12).
4. Recommendation that antigen tests NOT be used to screen for COVID-19, as a negative test is not helpful (page 12).

FCAAP RECOMMENDATIONS REGARDING SCHOOLS and COVID-19
November 23, 2020

The Florida Chapter of the American Academy of Pediatrics (FCAAP) believes it is important for children to return to school as soon as possible. The FCAAP also agrees with many of the recommendations of the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention (CDC) regarding the significant benefits to children in going back into the classroom on school campus for face-to-face education and the provision of other school services. While it is clearly in a child’s best interest that he/she attend classes on-campus, the benefits must outweigh the medical risks to the children, teachers, school staff, and families. This goal must be the most important factor. We are learning more about the coronavirus nearly every day, and these recommendations are subject to change as new information becomes available. Therefore, this is a living document and will be changed on an ongoing basis as new information is discovered. Please check back on this site (https://fcaap.org/parents/covid-19/) frequently for updates.

At the time of this writing viral positivity rates have begun to increase again in Florida, like other parts of the country--above the level for considered safer school opening. Having said that, we recognize that schools have already opened in most areas of the state. Dr. Anthony Fauci has recommended that the new positive test rate for SARS-CoV-2 which causes COVID-19 should be <5%, and there should be fewer than 10 cases per 100,000 people for schools to be at the safest level for reopening. According to the Florida DOH the new test positivity rate in Florida citizens, over the past week, has been 8.3%. Johns Hopkins notes a test positivity rate, over the past week, of 8.8%, and The PolicyLab at Children’s Hospital of Pennsylvania (CHOP) reports that Florida is now at an infection rate of 391/100,000 over the past week! This is well above the rate of 10 infections per 100,000 the PolicyLab recommends before society can fully reopen safely with risk mitigation factors, including social distancing, use of facemasks, frequent and adequate handwashing, and frequent cleaning of surfaces, all of which need to continue. Moreover, infection rates in most states are increasing at this time. In this setting we expect infections in schools to increase, as well. Schools and their local health departments must remain vigilant and closely collaborate concerning new cases and perform effective contact-tracing, isolation, and guaranteeing as recommended by the CDC. As the epidemic evolves so does the data and there are opportunities for local schools and districts to share best practices. It is therefore incumbent for school districts that have in-person attendance vigilantly adhere to mitigation

guidelines, as the fall and winter likely will take us into unchartered territory in terms of increasing and high rates of COVID-19 with its attendant risk to those in schools.

For up-to-date graphical presentations and easy to understand tables, we refer to the National Geographic Coronavirus Coverage website.8

There are recent studies showing children do not become as ill as older age groups with SARS-CoV-2, and they do not spread it as efficiently as adults do. The data are relatively limited to make definite conclusions about these contentions. However, if children, as a group, do not become as ill as adults, it does not mean every child with COVID-19 does not become ill. In one of the papers cited 12% of cases in children were severe.9 There is great concern about children with special healthcare needs infected with SARS-CoV-2 (asthma, obesity, diabetes, congenital heart disease, cystic fibrosis, and immune deficiencies, to name a few). Furthermore, children have become critically ill due to a rare multi-system inflammatory syndrome (MIS-C) related to COVID-19. In addition, lower spread rates from younger children to adults does not mean that children cannot spread the virus to adults. Adults, as we all know, have the potential to become very ill or die at a higher rate. Of note, some studies have noted that the risk of the Multi-System Inflammatory Syndrome in Children (MIS-C), which can cause a child to become very ill and involves multiple organ systems, appears to peak approximately 4-6 weeks after the rates of COVID-19 itself peaks in a population.10,11 Therefore, children who present ill with fever several weeks after a peak in community COVID-19 infections need to be sent to their physician as soon as possible for evaluation.

Recent data suggest that children and young adults 10-19 years of age can spread COVID-19 to adults and others at rates similar to those in the adult age ranges. In fact, the CDC reported recently that one teen index case infected 11 of 14 adults who stayed in the same house during a family reunion.12 Data from India also support the fact that the virus can be spread efficiently by children and adolescents.13

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Moreover, the CDC recently updated their guidelines by noting that airborne transmission is possible with SARS-CoV-2.\textsuperscript{14} While it is less efficient than measles, as an example, there have been cases of people becoming infected with SARS-CoV-2 who are more than 6 feet from an index case or who entered a room that recently had been occupied by someone with the infection. Moreover, recent data from Australia show that the virus can remain infectious on common smooth surfaces, such as phone screens, glass, paper currency, grab handles, and rails for up to 28 days at room temperature and longer at lower temperatures.\textsuperscript{15}

The above data have implications for all school settings.\textsuperscript{16} **Schools should continue to mandate masks and distancing as well as on-line and hybrid learning plans** to lessen potential exposures during local disease spikes and increasing positive case testing rates. The exact plan should be developed by each local school district in consultation with local pediatricians, family physicians, epidemiologists, infectious disease specialists, and local health departments.

The FCAAP recommends the following regarding masks in schools:

**There are no medical conditions that qualify for mask exemption**, since if any medical condition is severe enough to qualify for such (e.g., severe cardiac or pulmonary disease where the mask purportedly physiologically hinders or harms the child), then that child should not be attending school in person during a pandemic. **The data supporting the use of masks as a disease preventative measure are enormous, unambiguous, and should be followed.** The likelihood that a case of COVID-19 provides immune protection from future SARS-CoV-2 infection is unclear and remains a subject of intense research.\textsuperscript{17,18,19} Also, antibody tests do not discern when a patient was infected, or whether positive antibodies are the effective neutralizing types. Therefore, at this time, a positive antibody test (using test methods currently available to the public) or a past case of COVID-19 cannot be taken as proof of immunity to SARS-CoV-2.

1. Because of the above information even after infection with SARS-CoV-2 infection individuals MUST continue to wear a mask.

2. Children with sensory, developmental, or behavioral conditions should be carefully evaluated for face mask use. While studies on mask wearing in this population are limited, pediatric


developmental/behavioral specialists generally feel that most children with such disorders (e.g., level 1 autism spectrum disorder and less severe sensory conditions) can be successfully taught to wear a mask. However, it is conceivable that some children diagnosed with autism spectrum or sensory disorders, including any child in special education, may not be able to tolerate a mask or be taught to wear a mask (see #3 below). We understand this issue is difficult for children, parents, and educators alike. We recommend a well thought out, structured, behavioral/sensory approach to mask adaptation, as this best protects the child, educators, parents, and their families. In the extremely rare situation that a student is not able to wear and tolerate a mask, such student should not participate in regular school and alternative teaching arrangements should be made.

3. It is recommended that school systems review and update a child’s individual education plan (IEP) in deciding whether to allow mask exemptions in an individual student. The school system may wish to identify or appoint an individual or panel with pediatric medical and developmental/behavioral expertise to review all mask exemption applications. Since the issue is a behavioral and not a medical issue a note should not be needed from individual pediatricians. However, reviewers would require detailed information pertaining to the reason(s) for the exemption request. The FCAAP strongly recommends that parents and schools work with special needs children, on an ongoing basis, to help them become more comfortable wearing masks.

4. There are many mask types on the market and significant research has been conducted on their effectiveness in preventing spread of expiratory droplet and aerosol spread. Based on the best data currently available, the FCAAP recommends that N95 masks must be reserved for frontline healthcare worker use only. Acceptable masks for the general population, including school children, are (in order of best to lower protection):

- Surgical, polyester/cotton, 2-layer polypropylene, polypropylene swath, 2-layer cotton-pleated style, 2-layer cotton- Olson style, 1-layer cotton-pleated style, knitted mask with filter.

- **Masks with exhalation valves must not be allowed** since the valves allow exhalation of respiratory droplets without filtering. Therefore, valve masks are ineffective in protecting the contacts of an infected individual.

- **Gaiter-type neck fleeces and bandanas of all types must also be prohibited.** These masks strikingly create a shearing of exhaled respiratory droplets into finer aerosol jets that project farther than when wearing no mask at all.

- **Masks made of felt should also be prohibited.**

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The FDA has now approved a clear mask\textsuperscript{21}, the use of which would work best in teachers and support staff working with children with hearing impairment, autism spectrum disorder, or other special needs.

As in our organization’s July 2020 letter to Florida Governor Ron DeSantis\textsuperscript{22} expressing concern about opening schools in August, we now ask that the state and school systems help lower the risk to our children as much as possible once in-person school does begin or is continuing, based on the sound and proven epidemiological principle of preventing respiratory virus spread. In the absence of robust and rapid diagnostic testing for schools, the major tools for disease mitigation are personal (social) distancing, mask usage, strict hand hygiene, fomite prevention on surfaces (enhanced cleaning measures), and proper room ventilation.

A robust staff and student education program on the mitigation measures is important to the success of prevention. Schools should identify education “champions” to present and monitor compliance with recommended measures. Schools should work closely with their school board and administrators on how best to teach, implement, and monitor preventative measures like those recommended by the FCAAP.

**FCAAP RECOMMENDATIONS**

1. **Children must be up to date on vaccinations** at the time school starts. Vaccine completion currently stands at approximately 70% for 4-year-old children, and completion of Tdap is at approximately only 23% for 11-year-olds (Florida DOH data). Physicians, medical plans, the state DOH, hospital systems, and medical societies must continue working together in order that as many students as possible are up to date on immunizations. In addition, the state should implement a rule that children going to school receive the influenza vaccine as well as the meningococcal vaccine (if age/condition appropriate). Many other vaccines are already on the school-required vaccine schedule, but influenza illness will raise alarms, because symptoms of influenza are similar to those of COVID-19. Thus, many will mistakenly fear their child/student has COVID-19. Another important vaccine protects against meningococcus, a less common but severe cause of sepsis and meningitis. The initial symptoms of meningitis can mimic influenza or COVID-19. Teachers and staff should also receive the influenza vaccine.

2. **Screening for symptoms** is recommended at the beginning of every school day for each student, teacher, and staff member prior to entering school facilities. Please note that the FCAAP does NOT recommend temperature checks at the school. It is expensive, time-consuming, and not sensitive for early infection. Our organization does recommend that


parents check their child’s temperature at home before school, however. Those children who have a fever should not go to school.

As recommended by the PolicyLab at Children’s Hospital of Philadelphia\textsuperscript{23} symptoms for which school staff should screen are listed below. Students should not attend school if they meet these criteria:

**Two or more of the following**

- fever at home (>100.4\textdegree) or subjective fever at school
- chills
- muscle aches
- headache
- sore throat
- new decrease in smell or taste\textsuperscript{*}

\textsuperscript{*} This symptom is unique to COVID-19 and should warrant a high degree of suspicion.

**OR one of the following**

- cough
- shortness of breath
- difficulty breathing

Students meeting the above screening criteria and who arrive at school should be sent to a designated room separate from the school clinic and staffed for the student’s safety and reassurance. There they can await pick up and transport home with their parent/guardian, including, when appropriate, referral for further medical evaluation.

Recommended criteria for return to school are listed in Recommendation 13, below.

Some institutions and businesses have developed on-line screening check-in tools where individuals can report symptoms or lack thereof to an on-line portal. The results can be checked before, or as, individuals arrive to enter the building(s).

**Surveillance** should also attempt to identify students, teachers, and staff who were exposed to household or family members with COVID-19. Those who were exposed should be considered for quarantine away from schools themselves (and distance education for the students during that period). Note that web-based reporting has been helpful in some daycare centers in the country, identifying potential outbreaks early.

3. **Students should be in cohorts**, as much as possible, throughout the school day with as little interaction with other groups of children as can be achieved, including during lunchtime and recess. This should be true throughout the pre-K-12 system. There can be classroom cohorts within grade level-based cohorts. Since an exposure will inevitably occur, keeping students in cohorts would be important for subsequent testing, tracing, and isolation/quarantine if an exposure occurs. Further, the FCAAP recommends that students have assigned seats in buses, classrooms, laboratories, and even in extra-curricular activities. Having access to these seating charts will be very helpful in the facilitation of contact tracing in the event a child, teacher, or staff member becomes infected.

4. **Children and teachers should maintain a distance of at least 6 feet from each other** in classrooms and should not be in groups in which they are facing each other. In outdoor activities, the recommended distance between students and staff is also at least 6 feet, but if at least 6 feet is not possible then a minimum of 3 feet is acceptable provided mask wearing is mandated.²⁴ Students above the age of 5 years, teachers, and school staff should wear masks while in school. Personal Protective Equipment (PPE), including supplies for hand hygiene and extra cleaning supplies, must be made available to the schools (though stored in a setting that is safe for younger children). The CDC recommendations state: “Have adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent isopropyl alcohol (for staff and older children who can safely use hand sanitizer), paper towels, tissues, and no-touch trash cans.”²⁵

5. **Staggering times for school starting and ending** would decrease the number of children in school hallways and help with social distancing to limit close contact with parents or caregivers as much as possible. Lunches and other meals (from home or school-provided) are best eaten or provided in classrooms.

**Strict handwashing requirements** should be in place for use of such facilities. Classroom surfaces should be thoroughly cleaned with approved disinfectants²⁶ after every school day and between classroom cohorts as they change over throughout the school day. Use of bathrooms and water fountains needs to be regulated.

**Ventilation systems** for classrooms should be checked to assure they are in optimal working order. In poorly ventilated rooms with windows, opening the windows with supervision might be considered.

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6. **Children with special health care needs** are at higher risk of harm from COVID-19 infection. Their families should strongly consider whether their child’s educational needs can be met through virtual school. Schools should ensure that the goals of each child’s IEP can be met for children attending virtually. For children attending in-person, each child’s Individualized Health Plan (IHP) should include specific COVID-19 instructions. The Back to School Checklist, mentioned in previous versions of this paper, has been further updated and might be helpful for parents in deciding whether to send their children with special healthcare needs back to school. It can help guide their conversation with their healthcare provider. Children who are technology dependent should not attend school in person.

7. **Almost 30% of teachers are above the age of 50.** Those teachers who are greater than 50 years of age or have special healthcare needs should work in an area that is lower risk (virtual instruction, for example). Furthermore, these higher risk teachers should receive more enhanced surveillance and have more flexible work schedules. *The New York Times* recently published an article outlining a very interesting way to decrease risks to older teachers.

8. **School systems should make every effort to hire school nurses** for each school to help manage the recommendations and for symptom surveillance. There was already a marked dearth of school nurses in the Florida primary and secondary school systems before the COVID-19 pandemic, and it is now a critical issue. Even with a school nurse in every school, the position may be inundated by the breadth and volume of responsibilities during this pandemic. Schools can consider creative solutions such as volunteer assistance from healthcare professionals and institutions in the community, including medical education programs (e.g., medical schools, nursing schools).

9. During the school year students will, inevitably, present to the health room with other non-COVID-19 type complaints. These should be handled as usual, and the nurse should have a signed release under the Family Educational Rights to Privacy Act (FERPA) to allow her/him to call any child’s pediatric/family medicine/healthcare provider office when important. This would be particularly true for children with special healthcare needs. Please note that nebulizers should NOT be used in schools during the coronavirus pandemic. There are limited data on whether they increase the spread of COVID-19. However, out of an abundance of caution nebulizers should not be used. Inhalers used with spacers are thought to be safer.

10. **School buses and bus routes** need to be set up so as to allow social distancing of children. Extra cleaning will, of course, need to be maintained on the buses, in the same manner as in the schools. As noted in Recommendation 3 above, children should be assigned to seats in the

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buses and seating charts kept so that appropriate actions can be taken if an infected child is on the bus.

11. **Contact team sports** are not recommended by the FCAAP, as the viral infection rate is too high and sport activities place students in closer contact (see paragraph 2 of this document). Once the viral infection rates decrease to less than a five percent (5%) testing positivity rate for the county, involvement in contact sports should be less risky. The current outbreaks of COVID-19 among football teams in the USA spotlight the risk of contact sports.

**The Likely Relative Risks for COVID-19 Spread by Sport:**

**Highest risk:** Football, wrestling, competitive cheerleading, lacrosse, hockey, and martial arts.  
**Medium risk:** Basketball, volleyball, soccer, baseball, tennis, swim relays, and women’s lacrosse.  
**Lower risk:** Cross country (with staggered starts), golf, sideline cheerleading, weightlifting, bowling, fishing, swimming, track and field, and bicycling as long as athletes do not congregate before and after the event and follow social distancing and masking guidelines to prevent transmission of SARS-CoV2 virus.30,31 (Please see [CDC guidelines](https://bit.ly/CDCSaferSports) for safer sports involvement.)

Risk by sport type is an area still under research and the recommendations above are based on expert opinion until more peer-reviewed research is published. If a school does continue higher risk sports, the following **additional mitigation measures** should be considered:

- Limit number of attendees to sporting events to assure social distancing.  
- Require use of masks for attendees and individuals on sidelines.  
- Assure social distancing along sidelines.  
- Sanitize all equipment after use  
- No sharing of towels and, when possible, equipment (unless cleaned between uses).  
- Discontinue use of locker rooms for the team and staff and hold team meetings (such as pregame and halftime) outdoors away from spectators.  
- Provide students involved with contact sports options for either virtual learning or team member cohorted classroom learning only.

**Student athletes who test positive for COVID-19** should be seen by their physician and cleared before returning to sporting activities. This is especially true, since myocarditis (inflammation of the heart muscle) has been described in athletes who have been infected with SARS-CoV-2, even when their infection is asymptomatic. Furthermore, questionnaires regarding possible

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infection with SARS-CoV-2 should be added to the routine sports pre-participation examination.\textsuperscript{32} The American College of Cardiology has published guidelines for returning to play after COVID-19 infection, including a very helpful algorithm.\textsuperscript{33}

12. **Band and music involvement**, particularly the playing of wind instruments and singing, will require extra social distancing, and, of course, instruments will need to be cleaned very well. There are some data that the air plumes from brass and woodwind instruments are actually less than those produced from talking. Nonetheless, observers and those not playing instruments should wear masks in addition to social distancing. The safest areas for bands and choruses to perform are outdoors (which may be impractical on many days in Florida) or in large buildings such as a gymnasium. Activities involving singing are not recommended in classroom or tight settings. Projection of infectious material is much greater in magnitude from singers than from wind or brass instruments.

13. **Antigen tests for COVID-19 are not beneficial, and a negative antigen test should not be used in any setting, including school settings and sports, for decision making purposes.** These tests, despite their ease of use, have a high false negative rate, and, are, therefore, not helpful. The COVID-19 PCR test is much more sensitive and specific for COVID-19 infection, although, admittedly, it does take longer to run. As noted elsewhere in this paper (p5) antibody testing cannot be used to prove immunity nor can it tell when a person was infected.

14. The following table has been adapted from the Indiana Department of Health’s original table. It should aid decision-making about when children, teachers, and staff can return to school after a potential COVID-19 exposure.\textsuperscript{34}

**COVID-19: When a Student, Faculty, or Staff Member Can Return to School**

<table>
<thead>
<tr>
<th>Individual</th>
<th>Symptomatic</th>
<th>No Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Febrile or symptomatic but not tested with alternate explanation (strep, influenza, urinary tract infection, etc., as determined by a provider)</td>
<td>May return to school after 24 hours resolution of fever without fever-reducing medications.</td>
<td>N/A</td>
</tr>
</tbody>
</table>


| Not tested without alternate explanation | Must remain home for at least 10 days (20 days if significantly ill) from the first day symptoms appeared **AND** for 24 hours fever free without fever-reducing medications and with improvement of symptoms. | N/A |
| Test and Negative | If no alternative explanation, isolate until the COVID-19 test is back. If that test is negative and still having symptoms, continue isolation and consider re-testing for COVID-19. If test is negative and symptoms have resolved, isolate for 24 hours fever free without fever-reducing medicine **AND** with improvement of symptoms. The individual may return to school if tested negative. | May proceed with attending school. EXCEPTION: A known close contact (within 6 feet of a confirmed case for more than 15 minutes) must complete a 14-day quarantine, even if the test results are negative for COVID-19. Note the CDC recently changed the definition of exposure to include any cumulative exposure of 15 minutes in a 24-hour period, as well as a continuous 15 minute exposure. Either exposure will count. |
| Test and Positive | Must remain home in isolation for at least 10 days from the date symptoms began **AND** for 24 hours fever-free without fever-reducing medications and with improvement of respiratory symptoms. | Isolate at home for 10 days from the day the test was taken. *If the individual develops symptoms, isolation time starts on day 1 of symptoms as in symptomatic tested and positive (to Left).* |

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Close Contact (within 6 feet for more than 15 minutes of someone with confirmed COVID-19) | N/A If an individual becomes symptomatic, refer to the symptomatic scenarios. The individual must quarantine for 14 days after contact with the COVID-19 positive person even if the student has an alternative diagnosis for symptoms. | Quarantine for 14 days before returning to school AND must remain symptom-free. If individual develops symptoms, refer to the symptomatic scenarios.  

**Note:** QUARANTINE keeps a close contact with someone who has COVID-19 away from others. ISOLATION keeps someone who is sick or tested positive for COVID-19 without symptoms away from others, even in their own home.

14. As schools open, having robust and dependable data on infection rates in the state and infections in individual schools are critical. These data should be the basis on which to support whether schools can open as safely as possible and once open when it is appropriate to close classrooms and/or schools if necessary.

15. A classroom should go into quarantine if two members of the class (teacher or student) are exposed to SARS-CoV-2. If 20% of students in a school are exposed and considered under investigation for the SARS-CoV2 virus infection the entire school should go into quarantine.  

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38 Based on expert recommendation.
RESOURCES

AAP COVID-19 Planning Considerations: Guidance for School Re-entry:

CDC Guidelines on Reopening Schools 2020_07_23:

CDC Internal documents warn school reopening high risk:

CDC Consideration for Schools:

CDC Childcare, Schools and Youth Programs:

CDC Readiness and Planning Tool:

AAP, education groups stress the importance of safety in school reopening:
https://www.aappublications.org/news/2020/07/10/schoolreentrysafety071020

Children’s Hospital of Philadelphia (CHOP) PolicyLab:
https://policylab.chop.edu/covid-lab-mapping-covid-19-your-community

FCAAP Recommendations Regarding School Reopening – original publication 7.28.20
https://custom.cvent.com/EDE603C5145F48C8BBC5477DB676A0EB/files/444951ea982e446db7a77961aba82d66.pdf

FCAAP Recommendations Regarding School Reopening – updated 9.11.20
https://custom.cvent.com/EDE603C5145F48C8BBC5477DB676A0EB/files/8d6063ab8d414e99b27ff7155c4f6db1.pdf

FCAAP Recommendations Regarding School Reopening – updated 10.20.20
https://custom.cvent.com/EDE603C5145F48C8BBC5477DB676A0EB/files/d8fcb565fbdd445cfd2e787a84636815b.pdf
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