FCAAP Recommendations Regarding School Reopening

September 11, 2020
The infection rates in Florida have fallen at this time. According to data from the Florida Department of Health, Johns Hopkins University & Medicine, and the Children’s Hospital of Philadelphia (CHOP) PolicyLab, infection numbers are still higher than the infection rate recommended in our guidelines on July 28, 2020.¹

Since early August 2020, the American Academy of Pediatrics (AAP) has reported that >70 000 children have been infected with SARS-CoV-2.² As noted in the paper below approximately 12% of those have significant illness. Approximately 33% of children hospitalized required care in a pediatric intensive care unit.

The following updates have been made to the paper since its original publication on July 28, 2020:

1. Updated recommendations concerning students with special needs wearing masks (page 5, number 3).
2. Detailed recommendations regarding face mask types (page 5, number 4).
3. Further recommendations regarding cohorting of students (page 7, number 3).
4. Recommendation that children may be 3 feet distanced only if 6 feet distancing is not possible, masks are mandated, and there is adequate ventilation with outdoors being best (page 7, number 4).
5. Recommendation that children who are technology dependent not attend school in person (page 8, number 6).
6. Detailed recommendations regarding return to contact sports (page 9, number 11).
7. Recommendations concerning classroom or school closure criteria (page 11, number 14).
8. Recommendations regarding sharing of data about school infection rates (page 12 number 15).
9. Please note that national AAP guidelines for school reopening were updated on August 19, 2020.³

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 improved in Florida but continue to be above the level for considered safer school opening. The World Health Organization (WHO) has recommended that the new positive test rate for SARS-CoV-2 which causes COVID-19 should be <5% averaged over a 14-day period before states (and, hence, schools) can safely open. Therefore, the FCAAP recommends that school districts in locales with higher positive test rates (≥5%) that do not meet the 14-day criteria delay the start date for school until positive testing rates are lower. In many areas of the state coronavirus prevalence will not decrease enough in the next 4-6 weeks to make the benefits of school attendance outweigh the risks.

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. There is great concern about children with special healthcare needs infected

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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. Therefore, children who present ill with fever several weeks after a peak in community COVID 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. This new data has implications for junior high and high school settings. Schools should 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, and infectious disease specialists.

The FCAAP recommends the following regarding masks in schools:

1. **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.

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

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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.

As in our organization’s July 2020 letter to Florida Governor Ron DeSantis 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, 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.

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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 Policy Lab at Children’s Hospital of Philadelphia\textsuperscript{16} 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°) or subjective fever at school
- chills
- muscle aches
- headache
- sore throat

• new decrease in smell or taste*

* 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
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.”

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.

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

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. A Back to School Checklist, which has been written in both English and Spanish, 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

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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.20

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.21 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 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, safe involvement in sports might be possible. Please see CDC guidelines ([https://bit.ly/CDCSaferSports](https://bit.ly/CDCSaferSports)) for safer sports involvement. Contact sports such as organized football do present significant exposure and outbreak risks to players, coaches, and staff, as well as increase risk of spread within the general student body, teachers, and staff, not to forget increased risk to affected family units. If a school does start contact 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.
• 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.

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. 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.22

**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>
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<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>
<tr>
<td>Not tested without alternate explanation</td>
<td>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.23</td>
<td>N/A</td>
</tr>
</tbody>
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| Tested 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. |
| Tested 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). |
| 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.24 |

**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.

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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.25

RESOURCES


CDC Childcare, Schools and Youth Programs: https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/index.html


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

25 Based on expert recommendation.
GUIDELINE REVIEW, UPDATE, AND WRITING PANEL

D. Paul Robinson, MD, FAAP—Adolescent Medicine
Patricia Emmanuel, MD, FAAP—Pediatric Infectious Diseases
Michael Muszynski, MD, FAAP—Pediatric Infectious Diseases
Mobeen Rathore, MD, FAAP—Pediatric Infectious Diseases

CONTRIBUTORS

D. Paul Robinson, MD, FAAP—Adolescent Medicine
Lisa Gwynn, DO, MBA, FAAP—General Pediatrics and School Health
Patricia Emmanuel, MD, FAAP—Pediatric Infectious Diseases
Madeline Joseph, MD, FAAP—Pediatric Emergency Medicine
Toni Richards-Rowley, MD, FAAP—General Pediatrics
Michael Muszynski, MD, FAAP—Pediatric Infectious Diseases
Mobeen Rathore, MD, FAAP—Pediatric Infectious Diseases
Jeffrey Brosco, MD, FAAP—Developmental-Behavioral Pediatrics
Tommy Schechtman, MD, FAAP—General Pediatrics
Shannon J. Fox-Levine, MD, FAAP—General Pediatrics

CONTACTS

Alicia E. Adams, Esq. – FCAAP Executive Director
aadams@fcaap.org

Mrs. Melanie Range – FCAAP Membership & Communications Coordinator
mrange@fcaap.org

FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, INC.
1400 Village Square Boulevard, #3-87786, Tallahassee, FL 32312
Call or Text: 850/224-3939  Fax: 912/452-9050  www.fcaap.org