

Revised Public Health Guidance for Schools

PART 4 – TRANSITION JOINT GUIDANCE
MARCH 2021



Illinois
State Board of Education



Table of Contents

Executive Order	1
IDPH Health and Safety Requirements	2
Face Coverings and Other PPE	4
Social Distancing	6
Contact Tracing/Isolation/Quarantine.....	8
Symptom Screenings.....	8
Travel.....	10
Cleaning and Healthy Environments	10
Cafeterias/Food Service	12
Physical Education, Gymnasiums, Pools, and Locker Rooms	13
Playgrounds.....	14
Field Trips.....	14
Handwashing and Respiratory Etiquette	15
Additional Measures to Control the Spread of COVID-19 in Schools	16
COVID-19 Testing	16
Vaccination	16
Operations Strategies for Maintaining In Person Learning	17
References.....	19

This joint guidance from the Illinois Department of Public Health (IDPH) and the Illinois State Board of Education (ISBE) makes important updates to the essential, layered mitigation strategies that facilitate the safe return to in-person instruction. IDPH (along with its sister agency, ISBE) is issuing this guidance under its authority to protect the public health¹ in an effort to restrict and suppress the continued spread of COVID-19 and allow students across the State of Illinois to safely transition back to school. This updated joint guidance prevails in the event that any of it is in conflict with guidance previously issued by IDPH and ISBE. It reflects what we have learned about the transmission of COVID-19 in school settings, as more students in Illinois and across the country have returned safely to in-person learning during the 2020-21 school year. **This joint guidance supports the return to in-person instruction as soon as practicable in every Illinois community.**

On February 12, 2021, the Centers for Disease Control and Prevention (CDC) released updated guidance for operating schools ([Operational Strategy for K-12 Schools through Phased Mitigation](#)). According to the CDC:

K-12 schools should be the last settings to close after all other mitigation measures in the community have been employed and the first to reopen when they can do so safely. This implies that schools should be prioritized for reopening and remaining open for in-person instruction over nonessential business and activities ([CDC](#)).

The authors of the [CDC scientific brief, Transmission of SARS-CoV-2 in K-12 schools](#), published on February 12, 2021, in support of the new CDC guidance mentioned above conclude that schools are an important part of the infrastructure of communities. They cite several sources that suggest lower prevalence of disease, susceptibility, and transmission in children – especially those under the age of 10 – although additional studies are needed to further understand this. Further, the authors cite recent studies that have shown in-person learning was not associated with higher levels of transmission when compared to schools without in-person learning.^{2,3,4} Please note that additional studies are needed to better understand transmission in all populations; this does not mean that there are not risks of transmission or that older populations (teachers, school staff, parents) are not at risk of transmission when in-person learning is resumed. The February 12, 2021, CDC scientific brief referenced data that support mitigation efforts to ensure all students have access to safe in-person instruction to the greatest extent possible, which promotes learning recovery and the well-being of students and families. As of March 2021, 91 percent of Illinois school districts serving 89 percent of Illinois’ students were providing some in-person instruction, either through a blended model or fully in-person.

As a result of the CDC’s update, ISBE and IDPH have revised the public health requirements for schools and associated guidance in these guidelines. **This updated joint guidance prevails in the event that any of it is in conflict with guidance previously issued by IDPH and ISBE.**

On May 5, 2020, Governor JB Pritzker announced the [Restore Illinois](#) plan, which laid out a public health approach to safely reopen our state. IDPH is monitoring key indicators to identify early but significant increases of COVID-19 transmission in Illinois, potentially signifying resurgence. IDPH will monitor if these indicators show an increase in the COVID-19 disease burden with a simultaneous decrease in hospital capacity. These indicators can be used to

determine whether additional community mitigation interventions are needed for a region or statewide to control the further spread of COVID-19.

[Executive Order 2020-40](#), filed on June 4, 2020, allowed schools to reopen for limited in-person instruction in Phase 3. In-person instruction is strongly encouraged in Phase 4 and beyond. It is, however, critical to note that this does not signify a return to pre-pandemic operations. Appropriate social distancing, face masks, enhanced sanitation measures, and other mitigations will be necessary to ensure the safety of students, staff, and their families. This joint ISBE and IDPH guidance has been updated to be consistent with the CDC's mitigation strategies to reduce transmission of SARS CoV-2 in schools, as updated in [Operational Strategy for K-12 Schools through Phased Mitigation](#), released on February 12, 2021. Regardless of the level of community transmission, all schools must use and layer the following five essential mitigation strategies that are key to safely delivering in-person instruction and mitigating COVID-19 transmission in schools:

1. Require universal and correct use of appropriate personal protective equipment (PPE), including face masks;
2. Require social distancing be observed, as much as possible;
3. Require contact tracing in combination with isolation of those with suspected or confirmed COVID-19 and quarantine of close contacts, in collaboration with the local health department;
4. Require an increase in schoolwide cleaning and disinfection and maintenance of healthy environments; and
5. Require promotion and adherence to handwashing and respiratory etiquette.

The above five mitigation strategies update the IDPH guidelines that were contained in the Part 3 Joint Guidance issued on June 23, 2020. Detailed information has been added for greater clarity. Both the CDC's Operational Guidance dated February 12, 2021, and this joint guidance de-emphasize fever and symptom screening upon arrival at school, which are no longer recommended. Self-screening for COVID-19-like symptoms prior to arriving on school grounds or boarding school transportation continue to be recommended.

All public and nonpublic schools in Illinois serving prekindergarten through 12th-grade students must follow these essential, layered mitigation strategies. The CDC has developed a useful [toolkit](#) for schools to assess hazards and implement mitigation strategies to reduce the spread of COVID-19 in their buildings.

It is important to note that these requirements are subject to change pursuant to changing public health conditions and subsequent updated public health guidance, including when regions are subject to additional resurgence mitigations. School leaders should remain alert for any updates.

Consistent with the updated guidance from the CDC, **families of [students who are at increased risk of severe illness](#) (including those with special health care needs) or who live with people at increased risk** must be given the option of remote instruction.

In-person instruction should be prioritized over extracurricular activities, including sports and school events, to minimize risk of transmission in schools and protect in-person learning. Toward this goal, capacity limits for in-person learning, including non-academic school hour activities such as lunch, are now determined by the space's ability to accommodate social distancing, and not a set capacity limit number or percentage. Bus capacity remains at no more than 50 people per bus.

Additionally, IDPH is revising the recommendation for social distancing for in-person learning. Social distance for in-person learning is now defined as 3 to 6 feet for students and fully vaccinated staff. Maintaining 6 feet remains the safest distance, but schools can operate at no less than 3 feet in order to provide in-person learning. Current recommendations by the [American Academy of Pediatrics](#) and the [World Health Organization](#) support this range for in-person learning,^{5,6} as well as unpublished research from the [Mayo Clinic](#). **Unvaccinated staff should maintain 6 feet social distance as much as possible because adults remain more susceptible to infection than children. Universal masking as described on page 4 must be ensured regardless of whether schools use social distance of 3 feet or 6 feet.** Extracurricular activities should follow existing guidance on allowable social distancing, as described below. Close contacts necessitating quarantine if exposed to a confirmed case continue to be defined as having been within 6 feet of the confirmed case for a cumulative time period of 15 minutes over 24 hours and not fully vaccinated.

Decisions regarding whether to host safe and socially distanced events outside of school, such as open houses, registration, prom, graduation ceremonies, and other extracurricular events, will remain at the discretion of local school boards and superintendents, in consultation with local public health departments. Districts and schools may choose to hold these events virtually or in-person in a way that prioritizes the health and safety of participants and complies with the public health guidelines for schools listed above (e.g., use of face masks, capacity limits, social distancing, contact tracing, and increased cleaning and disinfection). Outdoor events, such as outdoor graduation ceremonies, should follow the latest guidance for these types of events, including Phase 4: [Outdoor Seated Spectator Events Guidelines](#). Indoor events should follow the latest guidance for these types of events, including [Phase 4: Meetings and Social Events](#). School athletics must comply with the latest [Restore Illinois All Sports Policy](#). Further specific guidance may come from ISBE and IDPH.

IDPH Health and Safety Requirements

Districts and schools should proactively prepare staff and students to prevent the spread of COVID-19 or any other infectious disease. All employees should be trained on health and safety protocols related to COVID-19 prior to resuming in-person instruction. Consider referring to recommendations and strategies from the CDC's multiple school webpages and resources, indexed from the [Schools and Child Care Programs: Plan, Prepare and Respond](#). Sections of this guidance were previously published in [Part 3](#) and may be updated.

Please also review IDPH's Frequently Asked Questions (FAQ) for Schools, which is continually updated.

1. Require universal and correct use of appropriate PPE, including face masks.

Face Masks

All persons, including students, teachers, school nurses and other health personnel, administrative and secretarial staff, food service personnel, custodial staff, public safety personnel, etc., on the grounds of all public and nonpublic schools that serve students in prekindergarten through grade 12 must wear a face mask at all times when in school or in transit to and from school via group conveyance (e.g., school buses), unless a specific exemption applies.

The [face mask should have two or more](#) layers to stop the spread of COVID-19 and should be worn over the nose and mouth, be secured under the chin, and should fit snugly against the sides of the face without gaps. School leaders, local leaders, and others respected in the community should set an example by correctly and consistently wearing masks.

Face masks must be worn at all times in school buildings even when social distancing is maintained, except as follows:

- When eating.
- When outdoors and physical distancing of 6 feet can be maintained.
- If using a face shield when other methods of protection are not available or appropriate. (<https://www.isbe.net/Documents/IDPH-Update-Appropriate-Use-Face-Shields.pdf>)
- While children are napping with close monitoring to ensure no child leaves their designated napping area without putting their face mask back on.
- For staff when alone in classrooms or offices with the door closed.
- For individuals who are younger than 2 years of age; those who have trouble breathing; or those who are unconscious, incapacitated, or otherwise unable to remove the face mask without assistance.

Strict adherence to social distancing must be maintained when face masks are removed in limited situations and monitored by school staff.

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

Most students, including those with disabilities, can tolerate and safely wear a face mask. Students with an Individualized Education Program or 504 Plan who are unable to wear a face mask or face shield due to a medical contraindication may not be denied access to an in-person education if the school is offering in-person education to other students. Staff working with students who are unable to wear a face mask or shield due to a medical contraindication should wear approved and appropriate PPE based on job-specific duties and risks and maintain social distancing as much as possible. Other students should also remain socially distant from students

who are unable to wear a face mask or face shield due to a medical contraindication. Schools should consult with their local public health department regarding appropriate PPE for these situations.

It is recommended that districts and schools update policies to require wearing a face mask while on school grounds and handle violations in the same manner as other policy violations.

There is significant evidence that face masks provide protection and decrease the spread of COVID-19. The face mask should have two or more layers and should fully cover the mouth and nose; the mask should fit snugly against the sides of the face with no gaps. Reusable face masks should be machine washed or washed by hand and allowed to dry completely after each use. Districts and schools may wish to maintain a supply of disposable face masks in the event that a staff member, student, or visitor does not have one for use. For additional information, visit [CDC: Guidance for Wearing Masks](#). Additionally, pay special attention to putting on and removing face masks for purposes such as eating. After use, the front of the face mask is considered contaminated and should not be touched during removal or replacement. Hand hygiene should be performed immediately after removing and after replacing the face mask. See CDC guidance on [how to safely wear and take off a mask](#) for additional instruction.

Face masks with exhalation valves or vents are not recommended for source control because they do not prevent the user from spreading respiratory secretions when they breathe, talk, sneeze, or cough. The CDC does **not** recommend use of single-layer athletic face masks (e.g., “gaiters”/neck warmers) as a substitute for multi-layered cloth face masks. Additional studies indicate that gaiters can be worn as face coverings when they contain two layers of fabric or a single layer can be folded to make two layers, according to updated CDC guidance (February 12, 2021).

Face shields do not provide adequate source control because respiratory droplets may be expelled from their sides and bottom. They may only be used as a substitute for face masks in the following limited circumstances:

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

Other Recommendations for use of PPE

Ensure that appropriate personal protective equipment is made available to and used by staff, as needed, based on exposure risk. Provide training to staff prior to the start of student attendance

on the proper use of PPE, including the sequence for putting on and removing PPE. In addition, training should also include directions on the proper disposal of PPE since inappropriate application or removal of PPE can increase the transmission. Employers are required to comply with Occupational Safety and Health Administration (OSHA) [standards](#) on bloodborne pathogens, including the [proper disposal of PPE and regulated waste](#).

The highest level of safety for a school health personnel who is screening a sick individual includes wearing a fit-tested N95 mask, eye protection with face shield or goggles, gown, and gloves. School health personnel performing clinical evaluation of a sick individual will use enhanced droplet and contact transmission-based precautions and should use appropriate PPE, including:

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

Any staff member who may be involved in the assessment or clinical evaluation of a student or staff member with COVID-19-like symptoms should be trained on the type of PPE required and how to put on and remove it correctly and safely.

Respirators such as N95 masks must be used as part of a written respiratory protection program. OSHA requires that N95 masks be fit-tested prior to use. This is an important step to ensure a tight fit for the mask to be effective in providing protection. If a fit-tested N95 mask is not available, the next safest levels of respiratory protection include, in the following order, a non-fit-tested N95 mask, a KN95 mask on the list approved by the U.S. Food and Drug Administration (FDA), or a surgical mask.

School health personnel evaluating a student or staff member who is later determined to be a probable or confirmed COVID-19 case would **not** be recommended for quarantine as a close contact if appropriate PPE is worn. Staff should continue to follow all [recommended infection prevention and control practices](#), including wearing a face masks for source control while at work, actively monitoring themselves for fever or COVID-19 symptoms prior to work and while working, and staying home if ill. See <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

2. Require social distancing be observed, as much as possible.

Physical distancing is essential to provide protection, minimize risk of exposure, and limit the number of close contacts. Capacity limits for in-person learning and associated activities (in classrooms, gyms, cafeterias, and multipurpose rooms) are now determined by the space's ability to accommodate social distancing -- not a set capacity limit number or percentage. Districts and schools should develop procedures to maintain social distancing. For in-person learning, this is defined as 3 to 6 feet for students and fully vaccinated staff with 6 feet being safest, but schools can operate at no less than 3 feet in order to provide in-person learning. Unvaccinated staff should maintain 6 feet social distance as much as possible because adults remain more susceptible to infection than children. **Further, the allowances of social distance of 3 to 6 feet**

mean schools must ensure universal masking. Districts and schools may wish to post visual reminders throughout school buildings and lay down tape or other indicators of safe distances in areas where students congregate or line up (e.g., arrival and departure, lunchroom lines, hallways, recess lines, libraries, cafeterias). **Strict adherence to 6 feet social distancing must be maintained and monitored by school staff when face masks are removed in the limited situations listed on page 4.**

Quarantine is still required for close exposure to a confirmed case within 6 feet of the confirmed case for a cumulative period of 15 minutes over 24 hours and not fully vaccinated. See No. 3 on page 8 for additional details on contact tracing. Districts and schools should evaluate the burden this could place on in-person learning when social distancing of less than 6 feet is employed, as more students and staff could be considered close contacts to a confirmed case.

Extracurricular activities should follow existing guidance for details on allowable social distancing. Outdoor events, such as outdoor graduation ceremonies, should follow the latest guidance for these types of events, including Phase 4: [Outdoor Seated Spectator Events Guidelines](#). Indoor events should follow the latest guidance for these types of events, including [Phase 4: Meetings and Social Events](#). School athletics must comply with the latest [Restore Illinois All Sports Policy](#). Further specific guidance may come from ISBE and IDPH.

Meal times represent one of the highest-risk settings within the school. Masks are removed and the act of eating and talking, usually with increased projection, can increase transmission risk. Schools must consider the number of students and adults in the classrooms or cafeteria during each breakfast and lunch period and ensure that all individuals maintain social distancing of at least 6 feet when masks are removed for eating, and 6 to no less than 3 feet when masks can be worn during the process of serving food, disposal, and leaving the cafeteria.

Districts and schools may wish to consider “staggering” schedules for arrivals/dismissals, hall passing periods, mealtimes, bathroom breaks, etc. to ensure student and staff safety. Staff and students should abstain from physical contact, including, but not limited to, handshakes, high fives, hugs, etc.

Staff break areas should be arranged to facilitate social distancing. Break times should be staggered to minimize exposure while eating with face mask off near others.

Evidence suggests that staff-to-staff transmission is more common than transmission from students to staff, staff to student, or student to student.^{7,8,9,10,11} Districts and schools must address staff-to-staff transmission and limit these exposures. Nonessential exposures among staff should be minimized, including both social and professional meetings. Measures to prevent transmission among staff, including promotion of COVID-19 precautions outside of the school and vaccination, will likely reduce in-school transmission.¹²

[Cohorts](#) (or “pods”) are groups of students -- and sometimes teachers or staff -- that stay together throughout the school day to minimize exposure to other individuals in the school environment. Cohorts should remain as static as possible by having the same group of students stay with the same teachers or staff (all day for young children, and as much as possible for older children). If

additional space is needed to support cohorting, consider all available safe spaces in school and community facilities. Limit mixing between cohorts.

It is important to consider services for students with disabilities, English Learners, and other disadvantaged students when developing cohorts so that such students may receive services within the cohort, but also to assure adherence to equity, integration, and other requirements of civil rights laws, including federal disability laws. If itinerant staff (e.g., speech language pathologists, Title I targeted assistance teachers) are required to provide services within existing cohorts, mitigation measures should be taken to limit the potential transmission of SARS-CoV-2 infection, including providing face masks and any necessary PPE for staff and children who work with itinerant staff. Itinerant staff members should keep detailed contact tracing logs.

Districts and schools may consider increasing social distancing measures when community transmission levels are substantial or high.

3. Require contact tracing in combination with isolation of those with suspected or confirmed COVID-19 and quarantine of close contacts, in collaboration with the local health department.

Individuals who exhibit symptoms should be referred to a medical provider for evaluation, treatment, and information about when they can return to school, according to the [IDPH Decision Tree \(Spanish translation\)](#). Confirmed cases of COVID-19 should be reported to the local health department by the school health personnel or designee as required by the [Illinois Infectious Disease Reporting](#) requirements issued by IDPH. Districts and schools should inform the school community of outbreaks per local and state health department guidelines while maintaining student and staff confidentiality rights. In addition to the previously referenced Decision Tree, schools should also reference [IDPH's Public Health Interim Guidance for Pre-K-12 Schools and Day Care Programs for Addressing COVID-19 \(October 14, 2020\)](#) for complete details on procedures for handling children/staff with symptoms, those who test positive, and those who are identified as close contacts, and must be quarantined.

Symptom Screenings

Districts and schools should require self-certification and verification for all staff, students, and visitors prior to entering school buildings. **IDPH and the CDC no longer recommend screenings upon arrival on the school grounds, but schools may continue this practice if preferred.** See the CDC's [Screening K-12 Students for Symptoms of COVID-19: Limitations and Considerations](#) for rationale regarding this decision.

Individuals who have or self-report a temperature greater than 100.4 degrees Fahrenheit/38 degrees Celsius or currently have known symptoms of COVID-19, such as fever, cough, shortness of breath or difficulty breathing, chills, fatigue, muscle and body aches, headache, sore throat, new loss of taste or smell, vomiting, or diarrhea, may not enter school buildings. Individuals who exhibit or self-report symptoms should be referred to a medical provider for evaluation, treatment, and information about when they can return to school, according to the [Decision Tree for Symptomatic Individuals](#).

A close contact is anyone (with or without a face mask) who was within 6 feet of a confirmed case of COVID-19 (with or without a face mask) for a cumulative total of 15 minutes or more over a 24-hour period during the infectious period. Repeated exposures result in an increased amount of time of exposure; the longer a person is exposed to an infected person, the higher the risk of exposure/transmission. The infectious period of close contact begins two calendar days before the onset of symptoms (for a symptomatic person) or two calendar days before the positive sample was obtained (for an asymptomatic person). If the case was symptomatic (e.g., coughing, sneezing), persons with briefer periods of exposure may also be considered contacts. Persons who have had lab-confirmed COVID-19 within the past 90 days or those fully vaccinated, according to CDC guidelines, are not required to quarantine if identified as a close contact to a confirmed case.

Contact tracing is used by health departments to prevent the spread of infectious diseases. In general, contact tracing involves identifying people who have a confirmed or probable case of COVID-19 (cases) and people who they came in contact with (close contacts) and working with them to interrupt disease spread. This includes asking people with COVID-19 to [isolate](#) and their contacts to [quarantine](#) at home voluntarily. The local health department will make the final determination on who is to be quarantined and for how long.

Districts and schools, as well as students and families, must work with local public health departments to facilitate [contact tracing](#) of infectious students, teachers, and staff, and consistent implementation regarding isolation of cases and quarantine of contacts. Schools can prepare and provide information and records to aid in the identification of potential contacts, exposure sites, and mitigation recommendations that are consistent with applicable laws, including those related to privacy and confidentiality. Health department collaboration with K-12 school administration to obtain contact information of other individuals in shared rooms, class schedules, shared meals, or extracurricular activities will expedite contact tracing. Health departments should ensure that schools that remain open have a sufficient number of contact tracers to complete case investigation and notify contacts within 48 hours of a positive test result.

Case investigation and contact tracing are essential interventions in a successful, multipronged response to COVID-19 and should be implemented along with other mitigation strategies. As K-12 schools resume in-person learning, case investigation and contact tracing with staff, teachers, and students should be part of a crucial strategy to reduce further transmission once a case is identified. Case investigation and contact tracing help to prevent further transmission of disease by separating people who have (or may have) COVID-19 from people who do not. Prompt identification, voluntary self-quarantine, and monitoring of those contacts exposed to COVID-19 can effectively break the chain of transmission and prevent further spread of the virus in a community.

Schools should institute a tracking process to maintain ongoing monitoring of individuals excluded from school because they have COVID-19-like symptoms, have been diagnosed with COVID-19, or have been exposed to someone with COVID-19 and are in quarantine. Tracking ensures CDC and local health authority criteria for discontinuing home isolation or quarantine are met before a student or staff member returns to school. Tracking methods include checking in with the school health personnel upon return to school to verify resolution of symptoms and that

any other criteria for discontinuation of quarantine have been met. Tracking should take place prior to a return to the classroom. Schools should communicate this process to all members of the school community prior to the resumption of in-person learning. This communication should be translated into the languages appropriate for the communities served.

Monitoring of continual communicable disease diagnoses and monitoring of student and staff absenteeism should occur through collaboration of those taking absence reports and school nurses/school health personnel. Employees and families must be encouraged to report specific symptoms, COVID-19 diagnoses, and COVID-19 exposures when reporting absences. Districts and schools should maintain a current [list of community testing sites](#) to share with staff, families, and students. Districts and schools must be prepared to offer assistance to local health departments when contact tracing is needed after a confirmed case of COVID-19 is identified. This may include activities such as identifying the individual's assigned areas and movement throughout the building.

Recommendations for Travelers

Travel increases chances of spreading and getting COVID-19. Details on COVID Travel Recommendations by Destination can be found on [CDC's Travel Page](#). The CDC currently requires testing of all international travelers before they enter the United States. Additionally, wearing a mask is required when traveling in, out of, or within the United States on any public conveyance, as well as in airports and public transport stations. The CDC also recommends that travelers:

- [Get tested](#) three to five days after travel AND stay home for seven days after travel.
 - Even with a negative test, travelers should stay home for the full seven days.
- If you don't get tested, it's safest to stay home for 10 days after travel.

Local health departments may have additional requirements for travelers and should be consulted with any questions about travel restrictions. For the most current travel recommendations, visit the [CDC's Travel Page](#). Although the local health department will not issue formal quarantine orders for travelers (unless testing positive), districts and schools are encouraged to request testing and quarantine from any students returning from travel.

4. Require an increase in schoolwide cleaning and disinfection and maintenance of healthy environments.

Districts and schools should develop sanitation procedures per recommendations of the [CDC](#), IDPH, and local health departments. More frequent cleaning and disinfection are necessary to reduce exposure. Visibly dirty areas should be scrubbed to remove visible dirt/soilage and then an approved disinfectant should be used to *kill* germs.

Clean frequently touched surfaces (e.g., door handles/knobs, desktops/tabletops, countertops, light switches, pencil sharpeners, computer keyboards, hands-on learning items, phones, toys, cubbies/coat and backpack areas, sinks and faucets, buses/vans) on a daily basis. Cloth toys or other cloth material items that cannot be disinfected should not be used.

Determine means to sanitize soft surfaces, such as carpeted areas, rugs and curtains. Clean with an approved soap/disinfectant for the surface area. Launder at high temperatures, if possible, and dry. If cleaning with soap and water is not feasible, disinfect with a household disinfectant that has been registered with the Environmental Protection Agency (EPA) and follow contact times on the label. Districts and schools may wish to revisit and revise any green cleaning policies. Vacuum as usual.

Districts and schools may wish to consider posting scheduled cleaning times and maintain appropriate documentation upon the completion of cleaning.

Ensure that [EPA-approved disinfectants](#) for use against the coronavirus are available to staff responsible for cleaning. If not available, consult your local health department for guidance on alternative disinfectants.

- Gloves and other appropriate [personal protective equipment](#) must be used during cleaning and disinfection. Ensure that appropriate PPE is made available to and used by staff, as appropriate, based on job-specific duties and risk of exposure.
- Always follow label directions.
- Allow the required wet contact time.
- Keep all disinfectants out of the reach of children.
- Do not mix bleach or other cleaning products and disinfectants together.

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

- Increase outdoor air ventilation, using caution in highly polluted areas.
 - When weather conditions allow, increase fresh outdoor air by opening windows and doors. Do not open windows and doors if doing so poses a safety or health risk (e.g., risk of falling, triggering asthma symptoms) to children using the facility.
 - Use child-safe fans to increase the effectiveness of open windows. Position fans securely and carefully in or near windows so as not to induce potentially contaminated airflow directly from one person over another. Strategically place fans to help draw fresh air into the classroom from open windows or to blow air from the classroom out open windows.
 - Decrease occupancy in areas where outdoor ventilation cannot be increased.

- Ensure ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space.
- Increase total airflow supply to occupied spaces, when possible.
- Disable demand-controlled ventilation controls that reduce air supply based on occupancy or temperature during occupied hours.
- Further open minimum outdoor air dampers to reduce or eliminate heating, ventilation, and air conditioning (HVAC) air recirculation. In mild weather, this will not affect thermal comfort or humidity. However, this may be difficult to do in cold, hot, or humid weather.
- Improve central air filtration:
 - [Increase air filtration](#) to as high as possible without significantly diminishing design airflow.
 - Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass
 - Check filters to ensure they are within service life and appropriately installed.
- Consider running the HVAC system at maximum outside airflow for two hours before and after the school is occupied.
- Ensure restroom exhaust fans are functional and operating at full capacity when the school is occupied.
- Inspect and maintain local exhaust ventilation in areas such as restrooms, kitchens, cooking areas, etc.
- Use portable high-efficiency particulate air fan/filtration systems to help enhance air cleaning (especially in higher risk areas, such as the health office).
- Generate clean-to-less-clean air movement by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers (especially in higher risk areas, such as the health office).
- Consider using ultraviolet germicidal irradiation as a supplement to help inactivate the virus that causes COVID-19, especially if options for increasing room ventilation are limited.
- Consider that ventilation is also important on school buses.

Other measures to maintain a healthy environment include decreasing use of shared objects (e.g., toys, electronics), modifying layouts (turning desks to face the same direction), installing physical barriers (sneeze guards and partitions), and closing communal shared spaces (dining halls and playgrounds). For additional recommendations, refer to [Operating schools during COVID-19: CDC's Considerations](#).

Cafeterias/Food Service

Cafeterias represent one of the highest-risk settings within the school. Masks are removed and the act of eating and talking, usually with increased projection, can increase transmission risk. Schools must consider the number of students and adults in the cafeteria during each breakfast and lunch period and ensure that all individuals maintain social distancing of at least 6 feet when eating, and 3 to 6 feet and masked during the process of serving food, disposal, and leaving the cafeteria.

If possible, tables should be forward facing with students sitting facing the same direction. Students should have assigned seats and sit with the same group each day. Supervision and monitoring must be in place and should be adequate to provide comprehensive observation. Modify layouts to reduce crowding and encourage social distancing (3 to 6 feet). Prioritize outdoor seating and distribution methods as much as possible. If possible, implement touchless methods for counting and claiming meals (e.g., tally sheets, barcode scanners). Provide [hand sanitizer](#) with at least 60 percent alcohol for use after handling money, cards, or keypads.

Alternate scheduling or add meal service times to reduce the number of individuals in a cafeteria at one time. Stagger the release of classrooms to the cafeteria to help ensure social distancing while students wait in line. If possible, consider delivering meals to classrooms where social distancing of 6 feet can be accommodated, or having students eat outdoors while ensuring social distancing is implemented. If students eat in the classroom, consider how an allergy-free area will be provided, as needed. Additionally, the room should be disinfected after eating prior to resuming classroom activities.

Meals should be individually plated. Buffets, salad bars, and the sharing of food and utensils should be prohibited. Ensure that students are served all items, including items such as milk and fresh fruits, rather than having students help themselves. Consider using disposable food service items (e.g., utensils, dishes). Ensure regular precautions are taken regarding [food allergies](#) and dietary needs. If disposable items are not available, ensure that all non-disposable food service items are handled with gloves and washed with dish soap and hot water or in a dishwasher.

Areas where students consume meals should be thoroughly cleaned and disinfected between groups and after meals. Food service personnel must use appropriate PPE, including gloves and face masks, while preparing and distributing food. Frequent hand hygiene should be required. Individuals should [wash their hands](#) after removing their gloves or after directly handling food service items that have been used.

Hand hygiene must be performed prior to and after eating a meal or consuming any food items. Face masks must be removed during eating, so it is important to ensure 6 feet distance between individuals. Considerations also should be given to food consumed during times other than mealtimes, such as by preschool students.

Communicate clear mealtime expectations with students and staff and ensure monitoring for adherence. Encourage students and other school staff to [wear masks](#) when they are not eating or drinking, especially when social distancing is hard to maintain (e.g., standing in line to discard food). For additional guidance, refer to CDC's [Safely Distributing School Meals During COVID-19](#).

Physical Education, Gymnasiums, Pools, and Locker Rooms

Physical activity can support students' overall health and well-being and help reduce stress and anxiety. Activities must allow for 6 feet distance between students as much as possible. Face masks must be worn at all times. Districts and schools must consider the risk-level of sports in physical education classes, if applicable, as detailed in the [Restore Illinois All Sports Policy](#). Educators should select outdoor physical education activities that allow natural social distancing

whenever feasible and if weather permits.

If physical education must be taught inside, consider using separate partitions in open spaces, utilizing markings on the gymnasium floor/wall/field to maintain distance between participants. Hand shaking, high fives, or other physical contact is prohibited. It is recommended that educators have access to technology to broadcast instruction to maximize social distancing (e.g., megaphone or microphone).

Districts and schools with pools must follow [IDPH guidance](#) on swimming facilities.

Districts and schools should consider allowing students to participate in activities without changing clothing. Shoe changes can be done in the classroom prior to arrival in PE. Lockers that are used should not be shared, and showers should not be required for activities.

The use of shared equipment is not recommended. Any shared equipment must be cleaned between each student use and disinfected at the end of each class. Fitness center equipment, such as treadmills, ellipticals, stationary bicycles, weights, etc., should be cleaned and sanitized before and after each class. Focus on frequently touched surfaces, such as keypads, hand weights, handles, etc. Maintaining 6 feet distance between participants may include using only every other treadmill/bicycle or installing dividers between machines or pieces of equipment.

Students and staff should perform hand hygiene at the start and end of each class period or when hands are visibly dirty. Students should also perform hand hygiene after the use of each piece of equipment.

Playgrounds

Playground equipment that is to be used should be monitored, and the number of students using each piece of equipment should be limited. Consider staggering playground times to allow one class in a playground space at one time rather than multiple classes playing together. Maintain appropriate cleaning of playground equipment. Any equipment/items that cannot be cleaned should not be utilized. Discourage the sharing of toys. High-touch surfaces made of plastic/metal, such as swings/slides, railings, and other play structures, should be cleaned routinely and disinfected as per the most recent CDC guidance.

Students should perform hand hygiene prior to touching playground equipment and upon return from the playground.

Field Trips

Decisions regarding whether to sponsor field trips will remain at the discretion of local school boards and superintendents, in consultation with local departments of public health. Districts and schools may choose to sponsor field trips virtually or in-person in a way that prioritizes the health and safety of participants and complies with the public health guidelines for schools (e.g., use of face masks, capacity limits, social distancing, contact tracing, and increased cleaning and disinfection). Whenever possible, outdoor field trips are encouraged.

5. Require promotion and adherence to handwashing and respiratory etiquette.

Districts and schools should encourage frequent and proper handwashing. Ensure availability of supplies, such as soap and paper towels, hand sanitizer, tissues, etc., for all grade levels and in all common areas of the building. Cloth towels should not be used. Handwashing with soap and water is always the first recommended line of defense, but where this is not feasible or readily accessible, the use of hand sanitizer with at least 60 percent alcohol may be used. Districts and schools should be cognizant of any students or staff members with sensitivities or allergies to hand sanitizer or soap and ensure easy access to alternative handwashing stations.

Hands should be washed often with soap and water for 20 seconds. Consider ways to build routines for hand hygiene into the school day. It is recommended that hand hygiene is performed upon arrival to and departure from school; after blowing one's nose, coughing, or sneezing; following restroom use or diaper changes; before food preparation or before and after eating; before/after routine care for another person, such as a child; after contact with a person who is sick; upon return from the playground/physical education; and following glove removal. Districts and schools should determine any "hot spots" where germ transmission may easily occur and ensure hand sanitation/handwashing supplies are readily available.

Additionally, districts and schools should adhere to recommendations for safe hand sanitizer use, including:

- Alcohol-based hand sanitizers should be used under adult supervision with proper child safety precautions and stored out of reach of young children to reduce unintended, adverse consequences. It will be necessary to ensure that students do not ingest hand sanitizer or use it to injure another person.
- Alcohol-based hand sanitizers must be properly stored – which includes away from high temperatures or flames – in accordance with National Fire Protection Agency recommendations.
- Hand sanitizers are not effective when hands are visibly dirty. Use soap and water to clean visibly soiled hands.
- Alcohol-based hand sanitizers do not remove allergenic proteins from the hands.
- Staff preparing food in the cafeteria/kitchen should ALWAYS wash their hands with soap and water. The IDPH Food Service Sanitation Code does not allow persons who work in school cafeteria programs to use hand sanitizers as a substitute for handwashing.
- The FDA controls sanitizers as over-the-counter drugs because they are intended for topical antimicrobial use to prevent disease in humans.

Educate staff and students on healthy hygiene and handwashing to prevent the spread of infection. Monitor to ensure adherence among staff and students. Schools may wish to post handwashing posters in the bathrooms, hallways, classrooms, and other areas, as appropriate. See CDC's [Handwashing: Clean Hands Save Lives](#) for free resources. Ensure availability of resources for teachers, school health personnel, and other staff members so they can appropriately train students or review handwashing procedures. [Various classroom lesson, activities, and resources](#) are available.

Respiratory etiquette should be taught and reinforced frequently. Respiratory etiquette practices include masking the nose and mouth with a tissue when coughing or sneezing, disposing of the used tissue in a trash receptacle, and then immediately washing hands. If wearing a mask, turn away from others and cough/sneeze into the crook of the elbow. If the mask become moist, soiled, or torn, it should be replaced with a clean, dry mask. Districts and schools should also consider [additional signage](#) to display on the correct methods for sneezing and coughing.

Staff and students should be directed and encouraged to avoid touching the face (eye, nose, mouth) to decrease the transmission of COVID-19 or other infectious diseases.

Additional Measures to Control the Spread of COVID-19 in Schools

COVID-19 Testing

Viral testing strategies are increasingly becoming an important part of a comprehensive mitigation approach. Testing is most helpful in identifying new cases to prevent outbreaks, reduce risk of further transmission, and protect students and staff from COVID-19. The [Decision Tree for Symptomatic Individuals](#) should be used to guide testing approaches of symptomatic staff or students and need for use of a polymerase chain reaction test for confirmation. For additional guidance on testing, including what types of tests are appropriate for use on asymptomatic individuals, please reference the IDPH Interim Guidance on [Rapid Point-Of-Care Testing for COVID-19 in Community Settings and Schools](#). Schools are encouraged to contact their local health departments for assistance with establishing testing within their buildings, including access to rapid testing kits.

The hierarchy of testing for COVID-19 in schools is first for persons with symptoms of COVID-19, followed by close contacts to a confirmed case, and all staff and students with possible exposure in the context of an outbreak. Testing may also be used for screening purposes. This involves serial testing of asymptomatic persons. Repeat testing of teachers, staff, and students is best used in schools where the risk of transmission is [moderate to high](#) and in collaboration with the local health department to determine the appropriateness of offering repeat testing to randomly selected asymptomatic teachers, staff, and students at the school. Testing teachers and staff should be prioritized over students in any sampling strategy, and older students should be prioritized over younger students. Persons who have recovered from COVID-19 in the past three months should be excluded from random selection. Contact tracing should immediately begin if anyone tests positive for COVID-19.

Vaccination

The State of Illinois has prioritized vaccine distribution to Illinois teachers and other school personnel by placing these individuals in the 1B vaccination priority group. Districts and schools should work with local public health departments to ensure school staff have access to vaccines and ensure that their teachers and staff know they can access vaccines at any of the [several mass vaccination sites around the state, pharmacies, federally qualified health center, and other providers](#).) Vaccinating teachers and school staff can be considered one layer of mitigation and protection for staff and students. Strategies that minimize barriers to access vaccination for teachers and other frontline workers, such as vaccine clinics at or close to the place of work, are optimal. School officials and health departments should work together to support messaging and

outreach regarding vaccination for members of school communities as they become eligible for vaccination in their jurisdictions. For example, school communication platforms can be leveraged for outreach to older adult family members of students, particularly for students living in multi-generational households. In later phases of vaccination, school communication can facilitate outreach to encourage vaccination of household members of school-age children as they become eligible.

Implementation of essential, layered mitigation strategies will need to continue until we better understand potential transmission among people who received a COVID-19 vaccine and there is more vaccination coverage in the community. In addition, vaccines are not yet approved for use in children under 16 years old. For these reasons, even after teachers and staff are vaccinated, schools need to continue mitigation measures for the foreseeable future, including requiring masks in schools and physical distancing as much as possible.

Operations Strategies for Maintaining In-Person Learning

Districts and schools should consult with their local public health departments as they transition to and from remote to in-person instruction. The [IDPH's Adaptive Pause and Metrics: Interim School Guidance for Local Public Health Departments](#) should be referenced when making decisions regarding adaptive pause. "K-12 schools should be the last settings to close after all other mitigation measures in the community have been employed, and the first to reopen when they can do so safely," according to the CDC.

The authors of a [CDC scientific brief, Operational Strategy for K-12 Schools through Phased Mitigation](#), conclude that schools are an important part of the infrastructure of communities. They provide safe, supportive learning environments for students and employ teachers and other staff.¹ Schools also provide critical services, including school meal programs and social, physical, behavioral, and mental health services.^{2,3} Schools have indirect benefits to the community, including enabling parents, guardians, and caregivers to work.^{2,4} They cite several sources that suggest lower prevalence of disease, susceptibility, and transmission in children -- especially those under the age of 10 -- although further studies are needed to further understand this. Further, the authors cite recent studies that have shown in-person learning was not associated with higher levels of transmission when compared to schools without in-person learning.^{2,3,4}

Health equity disparities also need to be considered when decisions are made to move away from in-person learning. The absence of in-person educational options may disadvantage children from all backgrounds, particularly children in low-resourced communities who may be at an educational disadvantage. These students may be less likely to have access to technology to facilitate virtual learning and more likely to rely on key school-supported resources like food programs, special education and related services, counseling, and after-school programs. Some parents and caregivers may have less-flexible jobs that do not permit staying at home to provide child care and aid with virtual learning if schools are closed to in-person instruction.

IDPH released the [Adaptive Pause and Metrics: Interim School Guidance for Local Health Departments](#) in August 2020 to guide districts and schools, in consultation with their local health departments, through decisions about reopening or pausing in-person learning based on available local data on case rates and test positivity. The document also identifies other indicators for temporary movement to remote or hybrid learning due to outbreaks or low adherence in the community to masking, and the importance that adherence.

Further, clusters of cases in schools in Illinois are closely monitored and, when needed, schools are encouraged by their local health departments to close for a period of time, usually two weeks, to contain further spread. This has proven effective.

At this time, IDPH and ISBE intend to continue to recommend usage of the [IDPH Adaptive Pause](#) document to aid districts and local health departments in determining when schools should implement closures and reopen. The two data elements used in the CDC's model are limited to test positivity rates and cases per 100,000. While both of these data elements are used in IDPH's Adaptive Pause document, they are not used solely to make decisions about closures. These data can be biased by large outbreaks or serial testing in health care and workplaces, and not directly impact risk at school. The IDPH Adaptive Pause approach uses these metrics, but also includes the judgement of local decision-makers and success in implementing mitigation measures before deciding to make changes in school operations. Further, the [scientific brief](#) provided by the CDC in support of its recommendations contradicts limiting decision-making to two data sets due to their limitations for conferring transmission risk within a school setting and/or among school-aged children.

While risk of exposure to COVID-19 in a school may be lower when indicators of community spread are lower, this risk is also dependent upon the implementation of school and community mitigation strategies. If community transmission is low but school and community mitigation strategies are not implemented or inconsistently implemented, then the risk of exposure and subsequent transmission of COVID-19 in a school will increase. Alternately, if community transmission is high, but school and community mitigation strategies are implemented and strictly followed as recommended, then the risk of transmission of COVID-19 in a school will decrease. Schools and districts should work closely with their local health departments to determine when it is safe to reopen or stay open based on both data and the school's ability to implement essential, layered mitigation strategies (CDC: [Operational Strategies for K-12 schools through Phased Mitigation](#)).

References

- ¹ The Department of Public Health Act, 20 ILCS 2305.
- ²National Academies of Sciences, Engineering, and Medicine (NASEM). Reopening K-12 Schools During the COVID-19 Pandemic: Prioritizing Health, Equity, and Communities. *Consensus study report from The National Academies Press*. 2020; doi:10.17226/25858
- ³Donohue JM, Miller E. COVID-19 and School Closures. *JAMA*. 2020;324(9):845-847. doi:10.1001/jama.2020.13092
- ⁴Russell FM, Ryan K, Snow K, Danchin M, Mulholland K, Goldfeld S. COVID-19 in Victorian Schools: An analysis of child-care and school outbreak data and evidence-based recommendations for opening schools and keeping them open. *Report from Murdoch Children's Research Institute and the University of Melbourne*. 2020; Published 2020 September 25.
- ⁵World Health Organization. What we know about COVID-19 transmission in schools: The latest on the COVID-19 global situation and the spread of COVID-19 in schools. October 21, 2020. Available at: https://www.who.int/docs/default-source/coronaviruse/risk-comms-updates/update39-covid-and-schools.pdf?sfvrsn=320db233_2
- ⁶ COVID-19 Guidance for Safe Schools *American Academy of Pediatrics Interim Clinical Guidance* January 5, 2021
- ⁷Ismail SA, Saliba V, Lopez Bernal J, Ramsay ME, Ladhani SN. SARS-CoV-2 infection and transmission in educational settings: a prospective, cross-sectional analysis of infection clusters and outbreaks in England. *Lancet Infect Dis*. 2020;S1473-3099(20)30882-3. Published online ahead of print 2020 December 8. doi:10.1016/S1473-3099(20)30882-3
- ⁸Gandini S, Rainisio M, Iannuzzo ML, Bellerba F, Cecconi F, Scorrano L. No evidence of association between schools and SARS-CoV-2 second wave in Italy. Preprint. *MedRxiv*. 2021; Posted online 2021 January 8. doi:10.1101/2020.12.16.20248134
- ⁹Stein-Zamir C, Abramson N, Shoob H, et al. A large COVID-19 outbreak in a high school 10 days after schools' reopening, Israel, May 2020. *Euro Surveill*. 2020;25(29):2001352. doi:10.2807/1560-7917.ES.2020.25.29.2001352
- ¹⁰Yung CF, Kam KQ, Nadua KD, et al. Novel coronavirus 2019 transmission risk in educational settings. *Clin Infect Dis*. 2020;ciaa794. Published online ahead of print 2020 June 25. doi:10.1093/cid/ciaa794
- ¹¹Ehrhardt J, Ekinici A, Krehl H, et al. Transmission of SARS-CoV-2 in children aged 0 to 19 years in childcare facilities and schools after their reopening in May 2020, Baden-Württemberg, Germany. *Euro Surveill*. 2020;25(36):2001587. doi:10.2807/1560-7917.ES.2020.25.36.2001587

¹²Jeremy A. W. Gold, MD^{1,2}; Jenna R. Gettings, DVM^{1,2,3}; Anne Kimball, MD^{1,2}; Rachel Franklin, MPH⁴; Grant Rivera, EdD⁵; Elana Morris, MPH¹; Colleen Scott, DrPH¹; Paula L. Marcet, PhD¹; Marisa Hast, PhD¹; Megan Swanson, MPH¹; Jazmyn McCloud, MPH⁴; Lemlem Mehari, MPH⁴; Ebony S. Thomas, MPH³; Hannah L. Kirking, MD¹; Jacqueline E. Tate, PhD¹; Janet Memark, MD⁴; Cherie Drenzek, DVM³; Snigdha Vallabhaneni, MD¹; Georgia K–12 School COVID-19 Investigation Team. Clusters of SARS-CoV-2 Infection Among Elementary School Educators and Students in One School District — Georgia, December 2020–January 2021; February 2020 *MMWR* (70)