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

The purpose of this guidance is to support education, public health, local leadership, and pediatricians collaborating with schools in creating policies for school re-entry that foster the overall health of children, adolescents, staff, and communities and are based on available evidence. Schools are fundamental to child and adolescent development and well-being and provide our children and adolescents with academic instruction, social and emotional skills, safety, reliable nutrition, physical/speech and mental health therapy, and opportunities for physical activity, among other benefits. Beyond supporting the educational development of children and adolescents, schools play a critical role in addressing racial and social inequity. As such, it is critical to reflect on the differential impact SARS-CoV-2 and the associated school closures have had on different races, ethnic and vulnerable populations. These recommendations are provided acknowledging that our understanding of the SARS-CoV-2 pandemic is changing rapidly.

Any school re-entry policies should consider the following key principles:

- School policies must be flexible and nimble in responding to new information, and administrators must be willing to refine approaches when specific policies are not working.
- It is critically important to develop strategies that can be revised and adapted depending on the level of viral transmission in the school and throughout the community and done with close communication with state and/or local public health authorities and recognizing the differences between school districts, including urban, suburban, and rural districts.
- Policies should be practical, feasible, and appropriate for child and adolescent's developmental stage.
- Special considerations and accommodations to account for the diversity of youth should be made, especially for our vulnerable populations, including those who are medically fragile, live in poverty, have developmental challenges, or have special health care needs or disabilities, with the goal of safe return to school.
- No child or adolescents should be excluded from school unless required in order to adhere to local public health mandates or because of unique medical needs. Pediatricians, families, and schools should partner together to collaboratively identify and develop accommodations, when needed.
- School policies should be guided by supporting the overall health and well-being of all children, adolescents, their families, and their communities. These policies should be consistently communicated in languages other than English, if needed, based on the languages spoken in the community, to avoid marginalization of parents/guardians who are of limited English proficiency or do not speak English at all.

With the above principles in mind, **the AAP strongly advocates that all policy considerations for the coming school year should start with a goal of having students physically present in school**. The importance of in-person learning is well-documented, and

there is already evidence of the negative impacts on children because of school closures in the spring of 2020. Lengthy time away from school and associated interruption of supportive services often results in social isolation, making it difficult for schools to identify and address important learning deficits as well as child and adolescent physical or sexual abuse, substance use, depression, and suicidal ideation. This, in turn, places children and adolescents at considerable risk of morbidity and, in some cases, mortality. Beyond the educational impact and social impact of school closures, there has been substantial impact on food security and physical activity for children and families.

Policy makers must also consider the mounting evidence regarding COVID-19 in children and adolescents, including the role they may play in transmission of the infection. SARS-CoV-2 appears to behave differently in children and adolescents than other common respiratory viruses, such as influenza, on which much of the current guidance regarding school closures is based. Although children and adolescents play a major role in amplifying influenza outbreaks, to date, this does not appear to be the case with SARS-CoV-2. Although many questions remain, the preponderance of evidence indicates that children and adolescents are less likely to be symptomatic and less likely to have severe disease resulting from SARS-CoV-2 infection. In addition, children may be less likely to become infected and to spread infection. Policies to mitigate the spread of COVID-19 within schools must be balanced with the known harms to children, adolescents, families, and the community by keeping children at home.

Finally, policy makers should acknowledge that COVID-19 policies are intended to mitigate, not eliminate, risk. No single action or set of actions will completely eliminate the risk of SARS-CoV-2 transmission, but implementation of several coordinated interventions can greatly reduce that risk. For example, where physical distance cannot be maintained, students (over the age of 2 years) and staff can wear face coverings (when feasible). In the following sections, we review some general principles that policy makers should consider as they plan for the coming school year. For all of these, education for the entire school community regarding these measures should begin early, ideally at least several weeks before the start of the school year.

Physical Distancing Measures

Physical distancing, sometimes referred to as social distancing, is simply the act of keeping people separated with the goal of limiting spread of contagion between individuals. It is fundamental to lowering the risk of spread of SARS-CoV-2, as the primary mode of transmission is through respiratory droplets by persons in close proximity. There is a conflict between optimal academic and social/emotional learning in schools and strict adherence to current physical distancing guidelines. For example, the Centers for Disease Control and Prevention (CDC) recommends that schools "space seating/desks at least 6 feet apart when feasible." In many school settings, 6 feet between students is not feasible without limiting the number of students. Evidence suggests that spacing as close as 3 feet may approach the benefits of 6 feet of space, particularly if students are wearing face coverings and are asymptomatic. Schools should weigh the benefits of strict adherence to a 6-feet spacing rule between students with the potential downside if remote learning is the only alternative. Strict adherence to a specific size of student groups (eg, 10 per classroom, 15 per classroom, etc) should be discouraged in favor of other risk mitigation strategies. Given what is known about transmission dynamics, adults and adult staff within schools should attempt to maintain a distance of 6 feet from other persons as much as possible, particularly around other adult staff. For all of the below settings, physical distancing by and among adults is strongly recommended, and meetings and curriculum planning should take place virtually if possible. In

addition, other strategies to increase adult-adult physical distance in time and space should be implemented, such as staggered drop-offs and pickups, and drop-offs and pickups outside when weather allows. Parents should, in general, be discouraged from entering the school building. Physical barriers, such as plexiglass, should be considered in reception areas and employee workspaces where the environment does not accommodate physical distancing, and congregating in shared spaces, such as staff lounge areas, should be discouraged.

The recommendations in each of the age groups below are not instructional strategies but are strategies to optimize the return of students to schools in the context of physical distancing guidelines and the developmentally appropriate implementation of the strategies. Educational experts may have preference for one or another of the guidelines based on the instructional needs of the classes or schools in which they work.

Pre-Kindergarten (Pre-K)

In Pre-K, the relative impact of physical distancing among children is likely small based on current evidence and certainly difficult to implement. Therefore, Pre-K should focus on more effective risk mitigation strategies for this population. These include hand hygiene, infection prevention education for staff and families, adult physical distancing from one another, adults wearing face coverings, cohorting, and spending time outdoors.

Higher-priority strategies:

- Cohort classes to minimize crossover among children and adults within the school; the exact size of the cohort may vary, often dependent on local or state health department guidance.
- Utilize outdoor spaces when possible.
- Limit unnecessary visitors into the building.

Lower-priority strategies:

- Face coverings(cloth) for children in the Pre-K setting may be difficult to implement.
- Reducing classmate interactions/play in Pre-K aged children may not provide substantial COVID-19 risk reduction.

Elementary Schools

Higher-priority strategies:

- Children should wear face coverings when harms (eg, increasing hand-mouth/nose contact) do not outweigh benefits (potential COVID-19 risk reduction).
- Desks should be placed 3 to 6 feet apart when feasible (if this reduces the amount of time children are present in school, harm may outweigh potential benefits).
- Cohort classes to minimize crossover among children and adults within the school.
- Utilize outdoor spaces when possible.

Lower-priority strategies:

- The risk reduction of reducing class sizes in elementary school-aged children may be

outweighed by the challenge of doing so.
- Similarly, reducing classmate interactions/play in elementary school-aged children may not provide enough COVID-19 risk reduction to justify potential harms.

Secondary Schools

There is likely a greater impact of physical distancing on risk reduction of COVID in secondary schools than early childhood or elementary education. There are also different barriers to successful implementation of many of these measures in older age groups, as the structure of school is usually based on students changing classrooms. Suggestions for physical distancing risk mitigation strategies when feasible:

- Universal face coverings in middle and high schools when not able to maintain a 6-foot distance (students and adults).
- Particular avoidance of close physical proximity in cases of increased exhalation (singing, exercise); these activities are likely safest outdoors and spread out.
- Desks should be placed 3 to 6 feet apart when feasible.
- Cohort classes if possible, limit cross-over of students and teachers to the extent possible.
  - Ideas that may assist with cohorting:
    - Block schedule (much like colleges, intensive 1-month blocks).
    - Eliminate use of lockers or assign them by cohort to reduce need for hallway use across multiple areas of the building. (This strategy would need to be done in conjunction with planning to ensure students are not carrying home an unreasonable number of books on a daily basis and may vary depending on other cohorting and instructional decisions schools are making.)
    - Have teachers rotate instead of students when feasible.
    - Utilize outdoor spaces when possible.
    - Teachers should maintain 6 feet from students when possible and if not disruptive to educational process.
    - Restructure elective offerings to allow small groups within one classroom. This may not be possible in a small classroom.

Special Education

Every child and adolescent with a disability is entitled to a free and appropriate education and is entitled to special education services based on their individualized education program (IEP). Students receiving special education services may be more negatively affected by distance-learning and may be disproportionately impacted by interruptions in regular education. It may not be feasible, depending on the needs of the individual child and adolescent, to adhere both to distancing guidelines and the criteria outlined in a specific IEP. Attempts to meet physical distancing guidelines should meet the needs of the individual child and may require creative solutions, often on a case-by-case basis.

Physical Distancing in Specific Enclosed Spaces

Bussing

- Encourage alternative modes of transportation for students who have other options.

- Ideally, for students riding the bus, symptom screening would be performed prior to being dropped off at the bus. Having bus drivers or monitors perform these screenings is problematic, as they may face a situation in which a student screens positive yet the parent has left, and the driver would be faced with leaving the student alone or allowing the student on the bus.
- Assigned seating; if possible, assign seats by cohort (same students sit together each day).
- Tape marks showing students where to sit.
- When a 6-foot distance cannot be maintained between students, face coverings should be worn.
- Drivers should be a minimum of 6 feet from students; driver must wear face covering; consider physical barrier for driver (eg, plexiglass).
- Minimize number of people on the bus at one time within reason.
- Adults who do not need to be on the bus should not be on the bus.
- Have windows open if weather allows.

Hallways

- Consider creating one-way hallways to reduce close contact.
- Place physical guides, such as tape, on floors or sidewalks to create one-way routes.
- Where feasible, keep students in the classroom and rotate teachers instead.
- Stagger class periods by cohorts for movement between classrooms if students must move between classrooms to limit the number of students in the hallway when changing classrooms.
- Assign lockers by cohort or eliminate lockers altogether.

Playgrounds

Enforcing physical distancing in an outside playground is difficult and may not be the most effective method of risk mitigation. Emphasis should be placed on cohorting students and limiting the size of groups participating in playground time. Outdoor transmission of virus is known to be much lower than indoor transmission.

Meals/Cafeteria

School meals play an important part in addressing food security for children and adolescents. Decisions about how to serve meals must take into account the fact that in many communities there may be more students eligible for free and reduced meals than prior to the pandemic.

- Consider having students cohorted, potentially in their classrooms, especially if students remain in their classroom throughout the day.
- Create separate lunch periods to minimize the number of students in the cafeteria at one time.
- Utilize additional spaces for lunch/break times.
- Utilize outdoor spaces when possible.
- Create an environment that is as safe as possible from exposure to food allergens.
- Wash hands or use hand sanitizer before and after eating.

Cleaning and Disinfection

The main mode of COVID-19 spread is from person to person, primarily via droplet transmission. For this reason, strategies for infection prevention should center around this form of spread, including physical distancing, face coverings, and hand hygiene. Given the challenges that may exist in children and adolescents in effectively adhering to recommendations, it is critical staff are setting a good example for students by modeling behaviors around physical distancing, face coverings and hand hygiene. Infection via aerosols and fomites is less likely. However, because the virus may survive in certain surfaces for some time, it is possible to get infected after touching a virus contaminated surface and then touching the mouth, eyes, or nose. Frequent handwashing as a modality of containment is vital.

Cleaning should be performed per established protocols followed by disinfection when appropriate. Normal cleaning with soap and water decreases the viral load and optimizes the efficacy of disinfectants. When using disinfectants, the manufacturers' instructions must be followed, including duration of dwell time, use of personal protective equipment (PPE), if indicated, and proper ventilation. The use of EPA approved disinfectants against COVID-19 is recommended (EPA List N). When possible, only products labeled as safe for humans and the environment (eg, Safer or Designed for the Environment), containing active ingredients such as hydrogen peroxide, ethanol, citric acid, should be selected from this list, because they are less toxic, are not strong respiratory irritants or asthma triggers, and have no known carcinogenic, reproductive, or developmental effects.

When EPA-approved disinfectants are not available, alternative disinfectants such as diluted bleach or 70% alcohol solutions can be used. Children should not be present when disinfectants are in use and should not participate in disinfecting activities. Most of these products are not safe for use by children, whose "hand-to-mouth" behaviors and frequent touching of their face and eyes put them at higher risk for toxic exposures. If disinfection is needed while children are in the classroom, adequate ventilation should be in place and nonirritating products should be used. Disinfectants such as bleach and those containing quaternary ammonium compounds or "Quats" should not be used when children and adolescents are present, because these are known respiratory irritants.

In general, elimination of high-touch surfaces is preferable to frequent cleaning. For example, classroom doors can be left open rather than having students open the door when entering and leaving the classroom or the door can be closed once all students have entered followed by hand sanitizing. As part of increasing social distance between students and surfaces requiring regular cleaning, schools could also consider eliminating the use of lockers, particularly if they are located in shared spaces or hallways, making physical distancing more challenging. If schools decide to use this strategy, it should be done within the context of ensuring that students are not forced to transport unreasonable numbers of books back and forth from school on a regular basis.

When elimination is not possible, surfaces that are used frequently, such a drinking fountains, door handles, sinks and faucet handles, etc, should be cleaned and disinfected at least daily and as often as possible. Bathrooms, in particular, should receive frequent cleaning and disinfection. Shared equipment including computer equipment, keyboards, art supplies, and play or gym equipments should also be disinfected frequently. Hand washing should be promoted before and after touching shared equipment. Computer keyboard covers can be used to facilitate cleaning between users. Routine cleaning practices should be used for indoor areas

that have not been used for 7 or more days or outdoor equipment. Surfaces that are not high touch, such as bookcases, cabinets, wall boards, or drapes should be cleaned following standard protocol. The same applies to floors or carpeted areas.

Outdoor playgrounds/natural play areas only need routine maintenance, and hand hygiene should be emphasized before and after use of these spaces. Outdoor play equipment with high-touch surfaces, such as railings, handles, etc, should be cleaned and disinfected regularly if used continuously.

UV light kills viruses and bacteria and is used in some controlled settings as a germicide. UV light-emitting devices should not be used in the school setting, because they are not safe for children and adults and can cause skin and eye damage.

Testing and Screening

Virologic testing is an important part of the overall public health strategy to limit the spread of COVID-19. Virologic testing detects the viral RNA from a respiratory (usually nasal) swab specimen. Testing all students for acute SARS-CoV-2 infection prior to the start of school is not feasible in most settings at this time. Even in places where this is possible, it is not clear that such testing would reduce the likelihood of spread within schools. It is important to recognize that virologic testing only shows whether a person is infected at that specific moment in time. It is also possible that the nasal swab virologic test result can be negative during the early incubation period of the infection. So, although a negative virologic test result is reassuring, it does not mean that the student or school staff member is not going to subsequently develop COVID-19. Stated another way, a student who is negative for COVID 19 on the first day of school may not remain negative throughout the school year.

If a student or school staff member has a known exposure to COVID-19 (eg, a household member with laboratory-confirmed SARS-CoV-2 infection or illness consistent with COVID-19) or has COVID-19 symptoms, having a negative virologic test result, according to CDC guidelines, may be warranted for local health authorities to make recommendations regarding contact tracing and/ or school exclusion or school closure.

The other type of testing is serologic blood testing for antibodies to SARS-CoV-2. At the current time, serologic testing should not be used for individual decision-making and has no place in considerations for entrance to or exclusion from school. CDC guidance regarding antibody testing for COVID-19 is that serologic test results should not be used to make decisions about grouping people residing in or being admitted to congregate settings, such as schools, dormitories, or correctional facilities. Additionally, serologic test results should not be used to make decisions about returning people to the workplace. The CDC states that serologic testing should not be used to determine immune status in individuals until the presence, durability, and duration of immunity is established. The AAP recommends this guidance be applied to school settings as well.

Schools should have a policy regarding symptom screening and what to do if a student or school staff member becomes sick with COVID-19 symptoms. Temperature checks and symptom screening are a frequent part of many reopening processes to identify symptomatic persons to exclude them from entering buildings and business establishments. The list of symptoms of COVID-19 infection has grown since the start of the pandemic and the manifestations of COVID-19 infection in children, although similar, is often not the same as that

for adults. **School policies regarding temperature screening and temperature checks must balance the practicality of performing these screening procedures for large numbers of students and staff with the information known about how children manifest COVID-19 infection, the risk of transmission in schools, and the possible lost instructional time to conduct the screenings.** Schools should develop plans for rapid response to a student or staff member with fever who is in the school regardless of the implementation of temperature checks or symptom screening prior to entering the school building. In many cases, it will not be practical for temperature checks to be performed prior to students arriving at school. **Parents should be instructed to keep their child at home if they are ill.** Any student or staff member with a fever of 100.4 degrees or greater or symptoms of possible COVID-19 virus infection should not be present in school.

In lieu of temperature checks and symptom screening being performed after arrival to school, **methods to allow parent report of temperature checks done at home may be considered.** Resources and time may necessitate this strategy at most schools. The epidemiology of disease in children along with evidence of the utility of temperature screenings in health systems may further justify this approach. Procedures using texting apps, phone systems, or online reporting rely on parent report and may be most practical but possibly unreliable, depending on individual family's ability to use these communication processes, especially if not made available in their primary language. Although imperfect, these processes may be most practical and likely to identify the most ill children who should not be in school. School nurses or nurse aides should be equipped to measure temperatures for any student or staff member who may become ill during the school day and should have an identified area to separate or isolate students who may have COVID-19 symptoms.

COVID-19 infection manifests similarly to other respiratory illness in children. Although children manifest many of the same symptoms of COVID-19 infection as adults, some differences are noteworthy. According to the CDC, children may be less likely to have fever, may be less likely to present with fever as an initial symptom, and may have only gastrointestinal tract symptoms. A student or staff member excluded because of symptoms of COVID-19 should be encouraged to contact their health care provider to discuss testing and medical care. In the absence of testing, students or staff should follow local health department guidance for exclusion.

Face Coverings and PPE

Cloth face coverings protect others if the wearer is infected with SARS CoV-2 and is not aware. Cloth masks may offer some level of protection for the wearer. Evidence continues to mount on the importance of universal face coverings in interrupting the spread of SARS-CoV-2. Although ideal, universal face covering use is not always possible in the school setting for many reasons. Some students, or staff, may be unable to safely wear a cloth face covering because of certain medical conditions (eg, developmental, respiratory, tactile aversion, or other conditions) or may be uncomfortable, making the consistent use of cloth face coverings throughout the day challenging. For individuals who have difficulty with wearing a cloth face covering and it is not medically contraindicated to wear a face covering, behavior techniques and social skills stories(see resource section)can be used to assist in adapting to wearing a face covering. When developing policy regarding the use of cloth face coverings by students or school staff, school districts and health advisors should consider whether the use of cloth face coverings is developmentally appropriate and feasible and whether the policy can be instituted safely. If not developmentally feasible, which may be the case for younger students, and cannot be done safely (eg, the face covering makes wearers touch their face more than they otherwise would),

schools may choose to not require their use when physical distancing measures can be effectively implemented. School staff and older students (middle or high school) may be able to wear cloth face coverings safely and consistently and should be encouraged to do so. Children under 2 years and anyone who has trouble breathing or is unconscious, incapacitated, or otherwise unable to remove a face covering without assistance should not wear cloth face coverings.

For certain populations, the use of cloth face coverings by teachers may impede the education process. These include students who are deaf or hard of hearing, students receiving speech/language services, young students in early education programs, and English-language learners. Although there are products (eg, face coverings with clear panels in the front) to facilitate their use among these populations, these may not be available in all settings.

Students and families should be taught how to properly wear (cover nose and mouth) a cloth face covering, to maintain hand hygiene when removing for meals and physical activity, and for replacing and maintaining (washing regularly) a cloth face covering.

School health staff should be provided with appropriate medical PPE to use in health suites. This PPE should include N95 masks, surgical masks, gloves, disposable gowns, and face shields or other eye protection. School health staff should be aware of the CDC guidance on infection control measures. Asthma treatments using inhalers with spacers are preferred over nebulizer treatments whenever possible. The CDC recommends that nebulizer treatments at school should be reserved for children who cannot use or do not have access to an inhaler (with spacer or spacer with mask). Schools should work with families and health care providers to assist with obtaining an inhaler for students with limited access. In addition, schools should work to develop and implement asthma action plans, which may include directly observed controller medication administration in schools to promote optimal asthma control. If required while waiting for a student to be picked up to go home or for emergency personnel to arrive, when using nebulizer or a peak flow meter, school health staff should wear gloves, an N95 facemask, and eye protection. Staff should be trained on proper donning and doffing procedures and follow the CDC guidance regarding precautions when performing aerosol-generating procedures. Nebulizer treatments should be performed in a space that limits exposure to others and with minimal staff present. Rooms should be well ventilated or treatments should be performed outside. After the use of the nebulizer, the room should undergo routine cleaning and disinfection.

School staff working with students who are unable to wear a cloth face covering and who must be in close proximity to them should ideally wear N95 masks. When access to N95 masks is limited, a surgical mask in combination with a face shield should be used. Face shields or other forms of eye protection should also be used when working with students unable to manage secretions.

On-site School Based Health Services

On-site school health services should be supported if available, to complement the pediatric medical home and to provide pediatric acute and chronic care. Collaboration with school nurses will be essential, and school districts should involve School Health Services staff early in the planning phase for reopening and consider collaborative strategies that address and prioritize immunizations and other needed health services for students, including behavioral health and reproductive health services.

Education

The impacts of lost instructional time and social emotional development on children and adolescents should be anticipated, and schools will need to be prepared to adjust curricula and instructional practices accordingly without the expectation that all lost academic progress can be caught up. Plans to make up for lost academic progress because ofschool closures and distress associated with the pandemic should be balanced by a recognition of the likely continued distress of educators and students that will persist when schools reopen. If the academic expectations are unrealistic, school will likely become a source of further distress for students (and educators) at a time when they need additional support. It is also critical to maintain a balanced curriculum with continued physical education and other learning experiences rather than an exclusive emphasis on core subject areas.

Students With Disabilities

The impact of loss of instructional time and related services, including mental health services as well as occupational, physical, and speech/language therapy during the period of school closures is significant for students with disabilities. Students with disabilities may also have more difficulty with the social and emotional aspects of transitioning out of and back into the school setting. As schools prepare for reopening, school personnel should develop a plan to ensure a review of each child and adolescent with an IEP to determine the needs for compensatory education to adjust for lost instructional time as well as other related services. In addition, schools can expect a backlog in evaluations; therefore, plans to prioritize those for new referrals as opposed to re-evaluations will be important. = Many school districts require adequate instructional effort before determining eligibility for special education services. However, virtual instruction or lack of instruction should not be reasons to avoid starting servicessuch as response-to-intervention (RTI) services, even if a final eligibility determination is postponed.

Behavioral Health/Emotional Support for Children and Adolescents

Schools should anticipate and be prepared to address a wide range of mental health needs of children and staff when schools reopen. Preparation for infection control is vital and admittedly complex during an evolving pandemic. But the emotional impact of the pandemic, financial/employment concerns, social isolation, and growing concerns about systemic racial inequity — coupled with prolonged limited access to critical school-based mental health services and the support and assistance of school professionals — demands careful attention and planning as well. Schools should be prepared to adopt an approach for mental health support.

Schools should consider providing training to classroom teachers and other educators on how to talk to and support children during and after the COVID-19 pandemic. Students requiring mental health support should be referred to school mental health professionals.

Suicide is the second leading cause of death among adolescents or youth 10 to 24 years of age in the United States. In the event distance learning is needed, schools should develop mechanisms to evaluate youth remotely if concerns are voiced by educators or family members and should be establishing policies, including referral mechanisms for students believed to be in need of in-person evaluation, even before schools reopen.

School mental health professionals should be involved in shaping messages to students and families about the response to the pandemic. Fear-based messages widely used to encourage strict physical distancing may cause problems when schools reopen, because the risk of exposure to COVID-19 may be mitigated but not eliminated.

When schools do reopen, plans should already be in place for outreach to students who do not return, given the high likelihood of separation anxiety and agoraphobia in students. Students may have difficulty with the social and emotional aspects of transitioning back into the school setting, especially given the unfamiliarity with the changed school environment and experience. Special considerations are warranted for students with pre-existing anxiety, depression, and other mental health conditions; children with a prior history of trauma or loss; and students in early education who may be particularly sensitive to disruptions in routine and caregivers. Students facing other challenges, such as poverty, food insecurity, and homelessness, and those subjected to ongoing racial inequities may benefit from additional support and assistance.

Schools need to incorporate academic accommodations and supports for all students who may still be having difficulty concentrating or learning new information because of stress associated with the pandemic. It is important that schools do not anticipate or attempt to catch up for lost academic time through accelerating curriculum delivery at a time when students and educators may find it difficult to even return to baseline rates. These expectations should be communicated to educators, students, and family members so that school does not become a source of further distress.

Mental Health of Staff

The personal impact on educators and other school staff should be recognized. In the same way that students are going to need support to effectively return to school and to be prepared to be ready to process the information they are being taught, teachers cannot be expected to be successful at teaching children without having their mental health needs supported. The strain on teachers this year as they have been asked to teach differently while they support their own needs and those of their families has been significant, and they will be bringing that stress back to school as schools reopen. Resources such as Employee Assistance Programs and other means to provide support and mental health services should be established prior to reopening. The individual needs and concerns of school professionals should be addressed with accommodations made as needed (eg, for a classroom educator who is pregnant, has a medical condition that confers a higher risk of serious illness with COVID-19, resides with a family member who is at higher risk, or has a mental health condition that compromises the ability to cope with the additional stress). Although schools should be prepared to be agile to meet evolving needs and respond to increasing knowledge related to the pandemic and may need to institute partial or complete closures when the public health need requires, they should recognize that staff, students, and families will benefit from sufficient time to understand and adjust to changes in routine and practices. During a crisis, people benefit from clear and regular communication from a trusted source of information and the opportunity to dialogue about concerns and needs and feel they are able to contribute in some way to the decision-making process. Change is more difficult in the context of crisis and when predictability is already severely compromised.

Food Insecurity

In 2018, 11.8 million children and adolescents (1 in 7) in the United States lived in a food-

insecure household. The coronavirus pandemic has led to increased unemployment and poverty for America's families, which in turn will likely increase even further the number of families who experience food insecurity. School re-entry planning must consider the many children and adolescentswho experience food insecurity already (especially at-risk and low-income populations) and who will have limited access to routine meals through the school district if schools remain closed. The short- and long-term effects of food insecurity in children and adolescents are profound. **Plans should be made prior to the start of the school year for how students participating in free- and reduced- meal programs will receive food in the event of a school closure or if they are excluded from school because of illness or SARS-CoV-2 infection.**

Immunizations

Existing school immunization requirements should be maintained and not deferred because of the current pandemic. In addition, although influenza vaccination is generally not required for school attendance, in the coming academic year, it should be highly encouraged for all students. School districts should consider requiring influenza vaccination for all staff members. Pediatricians should work with schools and local public health authorities to promote childhood vaccination messaging well before the start of the school year. It is vital that all children receive recommend vaccinations on time and get caught up if they are behind as a result of the pandemic. The capacity of the health care system to support increased demand for vaccinations should be addressed through a multifaceted collaborative and coordinated approach among all child-serving agencies including schools.

Organized Activities

It is likely that sporting events, practices, and conditioning sessions will be limited in many locations. Preparticipation evaluations should be conducted in alignment with the AAP Preparticipation Physical Evaluation Monograph, 5th ed, and state and local guidance.

Resources

- Coalition to Support Grieving Students
- Using Social Stories to Support People with I/DD During the COVID-19 Emergency
- Social Stories for Young and Old on COVID-19

Additional Information

If you need a print version of this guidance, use the Print icon at the top of the page or download a pdf here.

- Information for Parents on HealthyChildren.org: Returning to School During COVID-19
- Guidance Related to Childcare During COVID-19
- Guidance on Providing Pediatric Well-Care During COVID-19
- List of latest AAP News articles on COVID-19
- *Pediatrics* COVID-19 Collection
- COVID-19 Advocacy Resources(Login required)
- Centers for Disease Control and Prevention: Considerations for Schools
- Centers for Disease Control and Prevention: School Decision Tree

- [Centers for Disease Control and Prevention: Activities and Initiatives Supporting the COVID Response](#)

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