



CLAY COUNTY

PUBLIC HEALTH CENTER



COVID-19 and On-Site Learning Guidance for Schools & Early Childcare Centers

Last updated: July 29, 2021

Purpose

This guidance was created as a resource for school and early childcare education (ECE) administrators, including those with home-based programs and family childcare, to safely continue to full onsite learning and/or operations in Clay County, Missouri for the fall 2021 semester. It was developed from recommendations from lead public health agencies and expert pediatric organizations, including the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and Children's Mercy Hospitals and Clinics (CMH). It is to be used in conjunction with all local and state emergency orders and other guidance provided by Clay County Public Health Center (CCPHC). For both schools and ECEs, this guidance is meant to supplement – not replace – any federal or state regulations that require compliance. The adoption and implementation of this guidance should be done in collaboration with any regulatory agencies, and in compliance with state and local policies and practices.

Key Takeaways

- Students benefit from in-person learning and continuing in-person instruction in the fall 2021 is a priority.
- Young children benefit from in-person early child education; keeping ECE centers open in the fall 2021 is also a priority.
- Vaccination is currently the leading public health prevention strategy to end the COVID-19 pandemic. Promoting vaccination can help schools safely continue in-person learning as well as minimize outbreaks among students participating in extracurricular activities and sports.
- Due to the rapid spread of the delta variant of SARS-CoV-2, [CDC](#) and [AAP](#) recommend masks be worn indoors by all individuals (age 2 and older), unless medical or developmental conditions prohibit use.
- CDC recommends schools maintain at least 3 feet of physical distance between students within classrooms, combined with indoor mask wearing by people who are not fully vaccinated, to reduce transmission risk. When it is not possible to maintain a physical distance of at least 3 feet, such as when schools could not fully re-open while maintaining these distances, it is especially important to layer multiple other prevention strategies, such as indoor masking.
- Screening testing, proper ventilation, handwashing, and respiratory etiquette, staying home when sick and getting tested, contact tracing in combination with quarantine and isolation, and cleaning and disinfection are also important layers of prevention to keep schools safe.

- Students, teachers, and staff should stay home when they have signs of any infectious illness and be referred to their healthcare provider for testing and care.
- Many schools and ECEs serve children under the age of 12 who are not currently eligible for vaccination. Therefore, this guidance emphasizes implementing layered prevention strategies (e.g., using multiple prevention strategies together consistently) to protect people who are not fully vaccinated, including students, teachers, staff, and other members of their households.
- COVID-19 prevention strategies remain critical to protect people, including students, teachers, and staff, who are not fully vaccinated, especially in areas of moderate-to-high community transmission levels.
- School administrators should monitor community transmission, vaccination coverage, screening testing, and occurrence of outbreaks to guide decisions on the level of layered prevention strategies (e.g., physical distancing, screening testing).

Background

On July 27, 2021, the CDC issued [updated guidance](#)¹ for schools and for [childcare centers](#)² to reopen safely and to remain open. This updated guidance has been considered in conjunction with local conditions of the pandemic, transmission data from the spring 2021 semester and 2021 summer school session collected in partnership with local school districts, and published studies on in-school transmission. On July 18, the AAP [issued guidance](#)³ for safe schools, strongly advocating that all policy considerations for school plans start with the goal of keep students safe and physically present in school, stating *“Everything possible must be done to keep students in schools in-person.”*

Many schools and childcare centers serve children under the age of 12 who are currently not eligible for vaccination. They may also serve adults who are ineligible to receive the COVID-19 vaccine for many reasons. Therefore, this guidance emphasizes implementing layered prevention strategies to protect people who are not fully vaccinated, including students, teachers, staff, and other members of their households. The guidance is intended to help administrators select appropriate, layered prevention strategies and understand how to safely continue in-person learning. This guidance is based on what we currently know about SARS-CoV-2, the virus that causes COVID-19, and lessons learned from schools implementing COVID-19 prevention strategies. CCPHC may update this guidance as the pandemic evolves.

COVID-19 Among Children and Adolescents

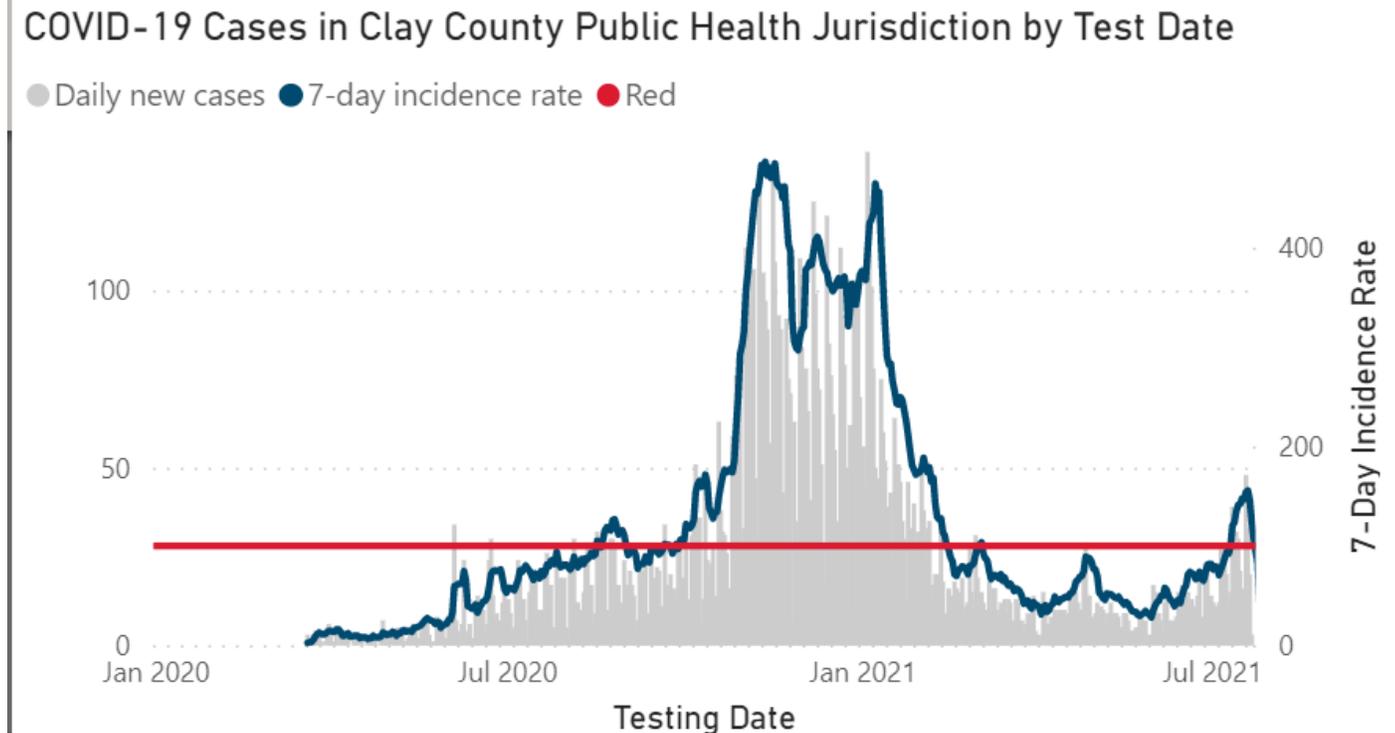
Children and adolescents (youth) can be infected with SARS-CoV-2, can get sick with COVID-19, and can spread the virus to others⁴⁻¹¹. In Clay County through July 2021, while the estimated cumulative rates of COVID-19 infection in children ages 5-17 years were half that of infection in adults ages 18-49, the proportion of cases with severe illness is similar (8-10%)^{12,13}. Estimated cumulative rates of infection and symptomatic illness in children ages 0-4 years are about half those in children ages 5-17 years, but have similar percentages of severe illness^{12,13}. These cumulative rates are based on cases reported to Clay County Public Health Center, as well as cases reported to the Kansas City, Missouri Health Department for Kansas City residents who live in Clay County.

Early in the pandemic, it was thought the incidence rate among youth was lower than among adults⁵⁻⁶. However, the lower incidence rates may have been partly due to children having fewer chances of exposure, due to suspension of school, daycare and activities, and a lower chance of being tested. When children and adolescents are tested at the same rate as adults, their rates of infection are comparable, and in some settings, higher, than in adults^{8,11}. Youth can also transmit SARS-CoV-2 to others. Outbreaks among youth attending camps, sports events, and schools have demonstrated this.

Compared with adults, youth who have COVID-19 are more often asymptomatic or have mild, non-specific symptoms, such as headache or sore throat¹⁵⁻¹⁹. Similar to adults with COVID-19, youth can

spread the virus to others when they do not have symptoms or have mild, non-specific symptoms and might not know they are infected and infectious. While children are less likely to develop severe illness or die from COVID-19, Clay County has seen children with severe COVID-19 illness and the extent to which children suffer long-term consequences of COVID-19 is still unknown²⁰.

Schools and SARS-CoV-2 transmission



CCPHC monitors new daily cases tested and a rolling 7-day incidence rate. In March and April 2021, cases continued to decline and show a sustained reduction, with the exception of a few weeks in late April. Starting in June, cases have steadily increased as the delta variant became the dominant strain of SARS-CoV-2 in the area. The average 7-day incidence rates for the last two weeks of June was 74 per 100,000 population, indicating substantial community transmission¹².

In the fall of 2020, school districts in Clay County, Missouri moved to hybrid learning and implemented robust mitigation measures to reduce COVID-19 transmission in schools. Mitigation measures include physical distancing, mask wearing, hand washing, cohort placing, ventilating, enhanced cleaning, daily screenings, contact tracing, and testing. Within the five school districts included in the study, a total of 837 student cases and 339 staff cases were identified as COVID-19 index cases, determined to be probable or PCR-confirmed cases. Among the student cases, 74 were determined to be in-school transmission, reflecting an attack rate of 0.17% (74 cases among estimated student population 42,530). Among the staff cases, 38 were determined to be in-school transmission, reflecting an attack rate of 0.83% (38 cases among estimated staff population 4,602)¹². Overall, these results show the attack rates for both students and staff are within the range found in other schools throughout the United States²⁻²⁷. **Error! Bookmark not defined.**

Schools should consider the level of community transmission as they assess the risk of transmission within their school. In Clay County, school-related outbreaks have most often been seen in extra-curricular activities or gatherings where masks are either not recommended or difficult to require. The few instances of outbreaks within the classroom setting have occurred when masks have not been worn or masking compliance has been low.

Transmission in Early Child Care (ECE) Settings

Although the data are more limited in ECE settings, we know that higher numbers of cases in early child care centers are observed when community rates are higher²⁸⁻²⁹. We also know children can acquire SARS-CoV-2 in ECE settings and transmit it to household and non-household members³⁰. Finally, when prevention strategies are in place, secondary transmission appears uncommon^{3,28-29}.

Organization

This support document is organized into 5 areas to address for fall 2021 learning:

1. Prevention Strategies to Reduce Transmission of SARS-CoV-2 in Schools and ECEs
2. Sports and Other Extracurricular Activities
3. New COVID-19 Variants
4. Vaccine Verification
5. Data-informed decision-making

Prevention Strategies to Reduce Transmission of SARS-CoV-2 in Schools and ECEs

This fall, schools will have a mixed population of both people who are fully vaccinated and people who are not fully vaccinated. Elementary schools and ECEs primarily serve children under 12 years of age who are not yet eligible for the COVID-19 vaccine. Other schools, such as middle schools or K-8 schools, may also have students who are not yet eligible for vaccination. Some schools, such as high schools may have a low proportion of students and staff who are fully vaccinated despite being eligible for the vaccine and widespread availability. These variations require administrators to make decisions about the use of COVID-19 prevention strategies in their schools to protect people who are not fully vaccinated.

The health of teachers, staff, students, and related households are first and foremost in planning for full onsite learning. The prevention strategies listed below are not a replacement of a district or school's emergency, crisis, or safety plan(s). Rather, these are specific strategies due to the current COVID-19 pandemic that should be included in any return to learn plan. If schools decide to return to a majority on-site or full on-site learning structure, CCPHC requests updated written protocols outline the school's plan to protect the health of its teachers, staff, students, and related households. While not specifically requested by ECEs, any who wish to have their COVID-19 protocols reviewed are welcome to submit.

Administrators should consider the following when they make decisions about implementing layered prevention strategies against COVID-19¹:

- Level of community transmission of COVID-19
- COVID-19 vaccination coverage in the community and among students, teachers, and staff
- Use of a frequent testing program for students, teachers, and staff who are not fully vaccinated.
- COVID-19 outbreaks or increasing trends in the school or community
- Ages of children in the schools and behavioral factors that may impact the risk of transmission and the ability to implement different prevention strategies

Promoting Vaccination

Reaching high levels of COVID-19 vaccination among eligible students, teachers, staff, and household members is one of the critical strategies to help schools continue in-person learning.

People 12 years and older are currently eligible for COVID-19 vaccination. Schools can promote vaccinations among students, teachers, staff, and household members by providing information about

the COVID-19 vaccines, encouraging vaccine trust and confidence, and establishing supportive policies/practices that make getting vaccinated as easy and convenient as possible.

To promote vaccination, schools and ECEs can:

- Visit www.vaccines.gov to find out where members of the school community can get vaccinated and promote COVID-19 vaccination locations near schools.
- Find ways to adapt [key messages](#)³⁰ to help school community members become more confident about the vaccine by using the language, tone, and format that fits the needs of the community and is responsive to concerns.
- Offer flexible, supportive sick leave options (e.g., paid sick leave) for employees to get vaccinated or who have side effects after vaccination.
- Provide students and families flexible options for excused absence to receive a COVID-19 vaccination and for possible side effects after vaccination.
- Work with local partners to offer COVID-19 vaccination for eligible students and eligible family members during pre-sport/extracurricular activity summer physicals.

What should be addressed in the school's protocol

- Strategies to increase vaccine acceptance and uptake

Consistent and Correct use of Masks

CDC and AAP recommend masking of all individuals over the age of 2 accessing schools, early childhood education and childcare settings due to the rapid spread of SARS-CoV-2 variants, in particular the delta variant. CCPHC supports this recommendation, particularly during periods of moderate, substantial or high community transmission (see Table 1). Current assessments of the Clay County transmission ratings can be found on the [CCPHC Data Hub, School Gating Criteria section](#)³¹.

AAP currently recommends universal masking in school for the reasons listed below³. [For ECEs](#)³², AAP recommends staff wear masks to protect infants and toddlers and encouraging children age 2 and older to wear masks. Administrators may opt to make mask use universally required (i.e., required regardless of vaccination status) within their respective congregate setting for these reasons.

- Having a student population that is not yet eligible for vaccination (e.g., schools with grades prekindergarten through 6).
- Increasing/substantial/high COVID-19 transmission within the school or their surrounding community.
- Increasing community transmission of a variant that is spread more easily among youth or is resulting in more severe illness from COVID-19 among youth, such as the delta variant.
- Lacking a system to monitor the vaccine status of students and/or teachers and staff.
- Difficulty monitoring or enforcing mask policies that are not universal.
- Awareness of low vaccination uptake within the student, family, or teacher/staff population or within the community.
- Responding to community input that many teachers, staff, parents, or students would not participate in in-person learning if mask use was not universal.

The best mask has 2-3 layers of breathable fabric, such as woven cotton, is worn snug over the mouth and nose without gaps and does not have an exhalation valve (this promotes spread of particles). The fit of a mask is improved by adding a nose wire to the top, tying ear loops tighter, tucking in the side or wearing a [mask fitter](#). Masks should never be worn while sleeping. During naptime, children should be as separated as possible. Cloth masks should be washed daily and when dirty. Additional masks should be available for students and staff if a mask is forgotten or becomes dirty and/or wet. Further [guidance for masks](#)³³ is available from the CDC.

[CDC's order](#)³⁴ applies to all public transportation, including school buses. Regardless of the mask policy at a school, passengers and drivers must wear a mask on school buses, including on buses operated both by public and private school systems.

Schools should provide masks to those students who need them (including on buses). No disciplinary action should be taken against a student who does not have a mask as described in the U.S. Department of Education [COVID-19 Handbook, Volume 1](#)³⁵.

The level of other prevention strategies may be impacted by a school or ECEs decision on masking requirements.

	Fully Masked	Partially Masked* or Unmasked
Diligent hand hygiene	Essential	Essential
Limiting sick students and staff within school buildings	Important. Masking has demonstrated the ability to limit the spread of multiple common respiratory viruses; however, sick children and staff should not attend until they have a negative COVID-19 test (PCR preferred). Strategies such as temperature screening have not demonstrated benefit over costs (monetary and person power) for prevention of COVID-19 transmission.	Essential
Quarantine of Exposed Contacts	<ul style="list-style-type: none"> Modified quarantine/exclusion for fully masked exposures along with monitoring for symptoms Shortened quarantine with evidence of negative test (will require mask wearing for completion of 14-day period) No quarantine if fully vaccinated 	<ul style="list-style-type: none"> Insufficient data to support modified quarantine in the partially masked environment. Shortened quarantine with evidence of a negative test (will require mask wearing for completion of 14-day period) No quarantine if fully vaccinated.
Screening testing	No current evidence of additive benefit to prevent secondary transmission	Could be considered to promote early identification of cases
Symptomatic testing	Essential	Essential
In-school transmission as measure to inform school policy/degree of prevention strategies employed	Essential – can be monitored via case reporting and contact tracing and should be performed by CCPHC in partnership with the school district	Essential – can be monitored via case reporting and contact tracing and should be performed by CCPHC in partnership with the school district
Community transmission/COVID-19 activity	Should not determine mode of learning (in-person vs virtual)	Should be considered to guide escalation of prevention strategies. If levels cross the

		identified threshold, universal masking should be employed prior to implementing virtual learning.
Vaccination rates (school and community)	Should be considered to transition from universal masking among teachers and students	Important for sustaining low rates of community transmission and reducing risk of spread when SARS-CoV-2 is circulating within the community
Distancing	Not as important, however the close contact definition remains 6 ft or closer, for at least 15 minutes in a 24-hour period. For students, the updated close contact definition is 3 feet.	When transmission rates are medium-high, distance as much as possible.
Cohorting	Less important in the setting of masking	Should be considered with known community transmission if masking is not re-implemented
Ventilation	Less important in the setting of masking	Increases in ventilation via improved indoor circulation of outdoor air or increased outdoor activity should be considered in the unmasked environment with SARS-CoV-2 is circulating in the community.

**Partially masked could include masking only of students and not staff or masking only of those who are unvaccinated*

Adapted from the ABC Science Collaborative³⁶

What should be addressed in the school's protocol

- The school district's position on masking
- If universal masking not implemented, what situations may require universal masking
- Requirement of masking on school buses per federal rule

Social distancing

- Establish social distancing as the norm, in a way that makes sense based on guidance from public health. Social distancing of at least 6 feet remains one of the best preventative measures for reducing the spread of COVID-19. CDC's updated guidance recommends "schools maintain at least 3 feet of physical distance between students within classrooms, combined with indoor mask wearing by people who are not fully vaccinated, to reduce transmission risk¹." The close contact definition remains at 6 feet, and contacts should be traced based on the 6-foot distance. In the **K–12 indoor classroom** setting, the close contact definition **excludes students** who were within **3 to 6 feet of an infected student** (laboratory-confirmed or a [clinically compatible illness](#)) where
 - both students were engaged in **consistent and correct use of well-fitting masks**; **and**
 - other [K–12 school prevention strategies](#) (such as universal and correct mask use, physical distancing, increased ventilation) were in place in the **K–12 school setting**.

This exception **does not** apply to teachers, staff, or other adults in the indoor classroom setting.

Schools should continue to emphasize the importance of staying home when sick. Perfect attendance awards should not be used during the 2021-2022 school year. Anyone, including visitors, who have symptoms of infectious illness, such as flu or COVID-19 should stay home and seek testing and care.

Cohorting when possible. 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 it is necessary to use multiple teachers or staff, limit the number of cohorts they work with. If additional space is needed to support cohorting, consider all available safe spaces in school and community facilities. If cohorting is being used, members of a cohort do not need to practice social distancing. Cohorting people who are fully vaccinated and people who are not fully vaccinated into separate cohorts is not recommended. It is the school or ECEs responsibility to ensure cohorting is done in an equitable manner that does not perpetuate academic, racial, or other tracking^{1,37}.

Provide flexible lunch options to allow for greater social distancing during a time when many will not be wearing masks.

Stagger school arrival and drop-off times or locations or put in place other protocols to limit direct contact with parents during drop-off and pick-up. For ECEs, parents may walk to their child's classroom for drop-off/pick-up, but time in the classroom should remain limited.

Limit any nonessential visitors, volunteers, and activities involving external groups or organizations with people who are not fully vaccinated as much as possible, particularly in areas where there is moderate-to-high COVID-19 community transmission. Schools should not limit access for direct service providers but can ensure compliance with school visitor policies.

What should be addressed in the school's protocol

- Attendance policies should be flexible to allow students & staff to stay home if they are not feeling well
- Social distancing strategies

Symptomatic Testing

Rapid detection of COVID-19 in symptomatic person allows for timely contact investigation and lowers the risk of in-school transmission. All students, teachers and staff should have access to COVID-19 testing if they are having symptoms consistent with COVID-19. If the school does not provide onsite testing, a list of resources should be provided to students, households, and staff as to where they can seek testing in the community. The CCPHC website continues to be updated with [current information on testing](#) in the county.

What should be addressed in the school's protocol

- Plan for testing of symptomatic persons

Screening Testing

Screening testing identifies infected people, including those with or without symptoms, who may be contagious, so that measures can be taken to prevent further transmission. Screening testing means regularly (e.g., weekly) testing people without symptoms with the goal of identifying and isolating COVID-19 positive individuals.

The Missouri Department of Health and Senior Services (DHSS) is offering K-12 schools the opportunity to participate in a [COVID-19 screening testing program](#)³⁸ using a pooled testing approach during the 2021-2022 school year. If schools wish to implement a screening testing program, CCPHC supports participation in this program. See Appendix A for additional guidance on when to offer screening testing.

What should be addressed in the school's protocol

- Whether the school wants to utilize this strategy, and plans for how this will be implemented in the school

Handwashing and Respiratory Etiquette

Support personal protective measures such as frequent handwashing, coughing/sneezing etiquette, and keeping hands away from face. Build in time during the day for teachers, staff, and students to engage in frequent hand washing as needed as the norm (e.g., before entry to the building, before/after meals, between classes, in the provision of student services, and when practicing coughing/sneeze etiquette). Ensure adequate access to hand sanitizers with greater than 60% ethanol or 70% isopropanol.

What should be addressed in the school's protocol

- How the school will promote frequent handwashing & good respiratory etiquette

Cleaning and Maintaining Healthy Facilities

In April 2021, CDC updated cleaning and disinfection guidance for schools³⁹. When no people with confirmed or suspected COVID-19 are known to have been in a space, cleaning once a day is usually enough to sufficiently remove virus that may be on surfaces and help maintain a healthy facility. Frequent cleaning & disinfection is recommended if:

- High transmission of COVID-19 in the community
- Low number of persons wearing masks
- Infrequent hand hygiene
- The space is occupied by people at increased risk for severe illness from COVID-19

What should be addressed in the school's protocol

- Cleaning protocols & schedules

Case Identification and Contact Tracing

Schools and staff should have a written plan for isolation and containment when a student or staff member is ill. Prior to the start of the school year, parents/ caregivers should be provided with pertinent information, including symptoms for which a student will be sent home, the time interval in which a student must be picked up by a parent/caregiver, and the criteria for return to school. All schools should identify a designated isolation area where exposed and/or ill students can be safely placed until picked up by a parent/caregiver. Students should not be left unattended. The school nurse or a designated staff member should monitor the student and ensure their safety until care is transitioned. Schools should consider having pre-printed templates for communication regarding positive cases and exposures to facilitate rapid communication.

The following terminology is used:

1. Exposure/Close Contact

- Close contact is within 6 feet for ≥ 15 minutes cumulative within the 48 hours prior to the onset of symptoms in a person with COVID-19 OR a positive COVID-19 test in an asymptomatic person. An exposure is also defined as direct physical contact (hugging, kissing, touching, etc.), sharing eating and drinking utensils, and contact with respiratory droplets (sneeze or cough) within the 48 hours prior to the onset of symptoms in a person with COVID-19 OR a positive COVID-19 test in an asymptomatic person. **Exception:** In the **K–12 indoor classroom** setting, the close contact definition **excludes students** who were within **3 to 6 feet of an infected student** (laboratory-confirmed or a [clinically compatible illness](#)) where

- both students were engaged in **consistent and correct use of well-fitting masks**; **and**
- other **K–12 school prevention strategies** (such as universal and correct mask use, physical distancing, increased ventilation) were in place in the **K–12 school setting**¹.

This exception does not apply to teachers, staff, or other adults in the indoor classroom setting..

2. Quarantine

Keeps someone who might have been exposed to the virus away from others. For COVID-19, quarantine is for 14 days from last contact with a person with confirmed or suspected COVID-19. This could be >14 days depending if the person with COVID-19 was unable to isolate from the exposed person (e.g. caregiver and child) or if additional exposure with COVID-19 positive persons occurred (e.g. multiple household members).

Reducing the length of quarantine may make it easier for people to quarantine by reducing the time they cannot work or be in school. A shorter quarantine period can also lessen stress on the public health system, especially when new infections are rapidly rising. Options include stopping quarantine

- after day 10 without testing
- after day 7, when receiving a negative test result (test must be PCR or NAAT and occur on day 5 or later).

After stopping quarantine, people should still watch for symptoms until 14 days after exposure. If symptoms develop, they should immediately isolate and contact their health care provider. They should also wear a mask, stay at least 6 feet from others, practice good hand hygiene, avoid crowds and get tested.

If the school has implemented universal masking, and appropriate masks were being worn correctly by both individuals during the time of exposure in the school setting, the individual who came in contact with the person with COVID-19 can continue to attend school AND participate in school-related activities, so long as they can wear a mask and maintain social distance. Those exposed individuals should self-monitor for symptoms and should also stay home from school at the first sign they do not feel well. Individuals who were exposed to someone diagnosed with COVID-19 while at school should continue always wearing their mask to further reduce the likelihood of transmitting the virus, and they should continue to quarantine at home for 14 days when not at school. The person who tests positive for COVID-19 is still required to isolate.

- It is important to note that if either the person with COVID-19 or the person exposed to that positive case was not following the school’s mask policy or was not wearing their mask appropriately during the time of exposure, the close contact should follow standard quarantine protocols and quarantine at home.

If the school has not implemented a universal masking, close contacts in the school setting should follow previously implemented quarantine protocols and quarantine at home per current quarantine protocols.

Please note that this does not relieve the school of contact tracing responsibilities, parent notifications, or symptom monitoring. This protocol option is only effective if other mitigation measures – including contact tracing – are in place and implemented correctly.

Individuals who had a laboratory confirmed (PCR Test) COVID-19 illness and fully recovered do NOT need to be quarantined if they are subsequently exposed within the next 3 months and do not have symptoms. Those who are antigen positive and symptomatic at the time of testing do not have to

quarantine if re-exposed within the next 3 months. Those who are antigen positive and asymptomatic will be assessed on a case-by-case basis but will likely result in quarantine. Those who were probable cases (a contact to a confirmed case and symptomatic) but did not have any testing done will need to quarantine due to re-exposure. Those that were antibody positive would also have to quarantine if re-exposed, because there is no way to know exactly when they were infected.

Those who have been vaccinated do not need to quarantine for exposure if they meet the following criteria:

- They are fully vaccinated (at least two weeks from receipt of the final dose)
- Have remained asymptomatic since the current exposure

3. Isolation

Isolation separates people who are infected with the virus away from people who are not infected.

- COVID-19 Symptomatic Isolation:
Isolation for:
 - At least 24 hours since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms AND
 - At least 10 days have passed since symptoms first appeared.
- COVID-19 Asymptomatic Isolation:
 - Isolation for at least 10 days from a positive test.

Any student or staff member with COVID-19 symptoms should not go to school. If a student is identified to have or develops COVID-19 symptoms once the student is already at school, they should be isolated, and the parent/ caregiver should be called for prompt pick up. If a staff member is identified to have COVID-19 symptoms, and they are already at school, they should be sent home immediately. School should designate a contact to determine when staff and students can return to school. See Appendix B for further recommendations regarding return to school.

4. Identification of a COVID-19 positive case

The school and/or school staff may be notified of a COVID-19 positive case prior to the local health department. To eliminate barriers for timely investigations from CCPHC, schools may notify the health center of these occurrences using the online reporting form (link below). It's important to note that this process is entirely voluntary but allows for more rapid investigation of cases and public health education of cases and contacts to assist schools with isolation and quarantine in families that are associated with schools.

https://ccph.iad1.qualtrics.com/jfe/form/SV_4SEXlw1cUiyapsV

Each school district has been assigned a CCPHC liaison to provide direct technical assistance with guidance on reporting positives, guidance on isolation/quarantine, guidance on contact investigations and other general questions.

5. School Case Investigation

Schools should familiarize themselves with the principles of contact tracing to rapidly facilitate identification of exposed students and staff and assist CCPHC.

- Schools should designate at least one staff member to pursue training in contact tracing. Online, free training can be found at the [Johns Hopkins Coronavirus Resource Center](#)
- Once a staff member or student has been diagnosed with COVID-19, the designated staff member in charge of contact tracing will identify any staff members or students that should be considered exposed based on classroom layouts, schedules, etc.
- The school liaison to the local health department will work with the health department to identify any exposed persons.
- Schools should be prepared to notify any exposed persons, so they can be immediately dismissed from school or informed to not return to school until their quarantine is complete. All school privacy requirements should be maintained¹⁸.
- Schools may choose, but are not required, to notify other staff and students that a person in the school was diagnosed with COVID-19. If schools choose to do this, they should highlight that staff and students were not exposed unless otherwise notified.
- Every effort should be made to keep the identity of the COVID-19 positive person private from other staff and students.
- The decision to close a classroom and/or school should be made in conjunction CCPHC.

Process on Communicating Close Contact to CCPHC

Schools may report close contacts through one of 3 options:

1. Utilize and become users of the CCPHC adopted system to monitor contacts called SARA Alert. Contact the CCPHC school liaison assigned to learn more about this process if interested.
2. Attach a “Close Contact Template” to the online report form when reporting the positive case to CCPHC. Please email the CCPHC school liaison for a copy of this reporting template.
3. A “Close Contact Template” may be emailed to the CCPHC school liaison if the message can be adequately encrypted. If a sender is unsure if their email server has the capability to encrypt emails, please contact IT for your organization. Please email the CCPHC school liaison for a copy of this reporting template.

What should be addressed in the school’s protocol

- Process for identifying cases and close contacts
- Quarantine protocols
- Process for communication with local public health

Sports and Other Extra-Curricular Activities

School-sponsored sports and extracurricular activities provide students with enrichment opportunities that can help them learn and achieve, and support their social, emotional, and mental health. Due to increased exhalation that occurs during physical activity, some [sports](#)⁴⁰ can put players, coaches, trainers, and others who are not fully vaccinated at [increased risk](#)⁴ for getting and spreading COVID-19. Close contact sports and indoor sports are particularly risky. Similar risks might exist for other extracurricular activities, such as band, choir, theater, and school clubs that meet indoors.

Prevention strategies for those who are not fully vaccinated in these activities remain important and should comply with school day policies and procedures. Students should refrain from these activities when they have symptoms consistent with COVID-19 and should be tested. Students who are not fully vaccinated and participate in indoor sports and other higher-risk activities should continue to wear masks and keep physical distance as much as possible. Schools may consider using screening testing for student athletes and adults (e.g., coaches, teachers, advisors) who are not fully vaccinated who participate in and support these activities to facilitate safe participation and reduce risk of transmission – and avoid risking in-person education due to outbreaks.

Coaches and school sports administrators should also consider specific sport-related risks for people who are not fully vaccinated:

- **Setting of the sporting event or activity.** In general, the risk of COVID-19 transmission is lower when playing outdoors than in indoor settings. Consider the ability to keep physical distancing in various settings at the sporting event (i.e., fields, benches/team areas, locker rooms, spectator viewing areas, spectator facilities/restrooms, etc.).
- **Physical closeness.** Spread of COVID-19 is more likely to occur in sports that require sustained close contact (such as wrestling, hockey, football).
- **Number of people.** Risk of spread of COVID-19 increases with increasing numbers of athletes, spectators, teachers, and staff.
- **Level of intensity of activity.** The risk of COVID-19 spread increases with the intensity of the sport.
- **Duration of time.** The risk of COVID-19 spread increases the more time athletes, coaches, teachers, staff and spectators spend in close proximity or in indoor group settings. This includes time spent traveling to/from sporting events, meetings, meals, and other settings related to the event.
- **Presence of people more likely to develop severe illness.** People at increased risk of severe illness might need to take [extra precautions](#)⁴¹.

Playgrounds and Physically Active Play

In general, children and adults do not need to wear masks when outdoors, including participating in outdoor play, recess, and physical education activities. When physically active play, physical education activities, and recess are held indoors, people who are not fully vaccinated should wear masks and maximize distance when possible.

Preventing COVID-19 for those who are not fully vaccinated in these activities remains important. Children who participate in indoor physical activity and other higher-risk activities should continue to wear masks, keep physical distance, and remain in their cohort as much as possible.

ECE providers who are planning structured physically active play should also consider risks for people who are not fully vaccinated:

- **Setting of the event or activity.** In general, the risk of COVID-19 transmission is lower when playing outdoors than in indoor settings. Consider the ability to keep social distancing in various settings at the event.
- **Physical closeness.** Spread of COVID-19 is more likely to occur in physical activity and sports that require sustained close contact.
- **Number of people.** Risk of spread of COVID-19 increases with increasing numbers of participants.
- **Level of intensity of activity.** The risk of COVID-19 spread increases with the intensity of the physical activity.
- **Duration of time.** The risk of COVID-19 spread increases the more time participants spend close to each other or in indoor group settings.
- **Presence of people more likely to develop severe illness.** [People at increased risk](#)⁴¹ of severe illness might need to take extra precautions.

New COVID-19 Variants and Prevention

New [variants](#)⁴² of the virus that causes COVID-19 are spreading in the Kansas City Metropolitan Area, including Clay County. The delta variant appears to be more quickly transmissible, more impactful on unvaccinated populations, and affecting more adolescents than what was experienced with COVID-19 last year. What we currently know is that COVID-19 vaccines authorized for use in the United States

offer protection against the circulating variants. CDC will continue to monitor variants to see if they have any impact on prevention strategies and how COVID-19 vaccines work in real-world conditions and will update guidance accordingly. For more information see CDC's [webpage on the effectiveness of COVID-19 vaccines](#)⁴³.

Vaccination Verification

Existing laws and regulations require certain vaccinations for children attending school, and K-12 administrators regularly maintain documentation of people's immunization records. Since many of the CDC recommended prevention strategies vary by vaccination status, schools should consult with their legal counsel to determine if they can request vaccine verification.

As part of their workplace COVID-19 policy, schools and ECEs should recognize that a worker who cannot get vaccinated due to disability (covered by the ADA), has a disability that affects their ability to have a full immune response to vaccination, or has a sincerely held religious belief or practice (covered by Title VII of the Civil Rights Act of 1964) may be entitled to a reasonable accommodation that does not impose a hardship on the school or ECE¹.

Data-Informed Decision Making

School administrators, working with CCPHC staff, may choose to assess the level of risk in the community since the risk of introduction of a case in the school setting is partially dependent on the level of community transmission. The transmission level will change over time and will be reassessed weekly for situational awareness and to continuously inform planning.

Key questions administrators will want to ask when forming their COVID-19 policies for the 2021-2022 school year³⁶:

1. At what levels of vaccination and community incidence it is safe to transition from universal masking in schools or ECEs?
2. Is the COVID-19 safety policy easily implemented and enforced? For example, if mask requirements are lifted for those who are vaccinated, how will staff monitor who should and should not be masked? Will administrators have consistent access to updated vaccination information for students and staff?
3. How will the absence of any prevention strategy affect those students and household members who are already hesitant to return to school and for those who are medically fragile, unable to be vaccinated, or live with someone who is at high risk of death from COVID-19 disease?
4. How might existing quarantine policies affect the ability of students and staff to stay in school and participate in extracurricular activities if they are identified as close contacts?
5. If students become infected, what is the risk to local families and the community at large?
6. With variants that are more infectious, are there systems in place to rapidly detect and mitigate spread within schools and the community?
7. Are administrators prepared to reinstitute masking, as needed, to mitigate spread and avoid classroom or school building closures?

While risk of exposure to SARS-CoV-2 in a school may be lower when indicators of sustained community spread are lower, this risk is also dependent upon the implementation of school and community prevention strategies. If community transmission is low but school and community prevention strategies are not implemented or inconsistently implemented, then the risk of exposure and subsequent transmission of SARS-CoV-2 in a school will increase. Alternately, if sustained community transmission is high, but school and community transmission strategies are implemented and strictly

followed as recommended, then the risk of transmission of SARS-CoV-2 in a school will decrease. See Table 1 in Appendix A for the CDC thresholds of community transmission.

Some examples of scenarios or metrics that would trigger discussion around closure or return to hybrid learning are below. Schools should have a return to hybrid plan in place to ensure a smooth transition, if necessary

Event	Action Taken
Three clusters* within a school within a 14-day period	District leadership will discuss the safety benefits of school closure with the school board, an independent body, CCPHC, and key stakeholders
More than three clusters** within a 14-day period <u>per</u> 10,000 students in a school district	District leadership will discuss the safety benefits of school closure with the school board, an independent body, CCPHC, and key stakeholders
Substantial secondary transmission*** in a school that does not rise to level of a cluster	District leadership will discuss the safety benefits of school closure with the school board, an independent body, CCPHC, and key stakeholders
Substantial secondary transmission*** in a school district	District leadership will discuss the safety benefits of school closure with the school board, an independent body, CCPHC, and key stakeholders

Modified from ABC Science Collaborative³⁶

*Cluster is defined as 2 or more cases

**In school districts of <10,000, greater than two clusters

***Substantial secondary transmission is defined as >5 cases of COVID-19, within-school transmission per 1,000 students within a 14-day period

Mental and Behavioral Health Support

It is recommended to collaborate with your school/school district mental health team to determine the best tools and interventions for your school community. For ECEs, the Office of Child Care in the Administration for Children and Families has a list of [mental health and wellness resources](#)⁴⁴ that may be beneficial. Missouri’s Early Care and Education Connections also has a [list of resources](#) for supporting emotional health⁴³.

Appendix A

Table 1. Recommended Thresholds for Assessing Level of Community transmission

Indicator	Low Community Transmission	Moderate Community Transmission	Substantial Community Transmission	High Community Transmission

Total new cases per 100K in the past 7 days	0-9	10-49	50-99	>=100
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Table 2. Screening Testing Recommendations for K-12 Schools by Level of Community Transmission

	Low Community Transmission	Moderate Community Transmission	Substantial Community Transmission	High Community Transmission
Students	Do not need to screen students	Offer screening testing for students who are not fully vaccinated at least once per week.		
Teachers and Staff	Offer screening testing for teachers and staff who are not fully vaccinated at least once per week.			
High risk sports and activities	Recommend screening testing for high-risk sports* and extracurricular activities** at least once per week for participants who are not fully vaccinated.		Recommend screening testing for high-risk sports* and extracurricular activities** at least twice per week for participants who are not fully vaccinated.	Cancel or hold high-risk sports and activities virtually to protect in-person learning, unless all participants are fully vaccinated.
Low-and intermediate-risk sports and activities	Do not need to screen students participating in low- and intermediate-risk sports*	Recommend screening testing for low- and intermediate-risk sports at least once per week for participants who are not fully vaccinated.		

Appendix B

School Workflow Guide for COVID-19

~Updated 3/22/2021~

1. School Notified of or Identifies a Positive Case for Coronavirus

Action: Positive student, teacher, staff, volunteer, etc. immediately excluded from school activities under school policy

Goal: Separate anyone who are actively infectious with the virus away from people who are not infected

Exclusion can end after:

Symptomatic Case: At least 24 hours since resolution of fever without the use of fever-reducing medications and improvement in symptoms AND At least 10 days have passed since symptoms first appeared

Asymptomatic Case: 10 days from a positive test based on the **collection date of the sample**

2. School Identifies Close and Direct Contacts and Excludes from School through Contact Tracing

Action: Determine who was exposed to the positive case during their infectious period through contact tracing

Goal: Keep the virus from spreading by excluding those who might become contagious after their exposure

When to Initiate Contact Tracing

The need for contact tracing can be determined based on presence of symptoms and if COVID-19 exposure happened

COVID-19 Symptom Guide

High-Risk Symptoms	Moderate- Risk Symptoms
<ul style="list-style-type: none"> • New cough • Difficulty breathing • Loss of taste/smell <p>*Fever in adults should be considered a high-risk symptom</p>	<ul style="list-style-type: none"> • Fever $\geq 100.4^{\circ}$ or chills • Congestion/ runny nose • Nausea/ vomiting/ diarrhea • Sore throat • Headache • Muscle or body ache

Scenario 1

	Question	Answer
Screening Results	What symptoms are they showing?	1 moderate-risk symptom
	Did they have a	No exposure to someone with COVID-19

	COVID-19 Exposure?	
Actions	Should they be tested?	No
	When can they return to School?	Return to school 24 hours after fever resolution and symptom improvement OR If the provider believes that an alternate diagnosis is the cause of signs and symptoms, return precautions should be specific to diagnosis
	Is contact tracing recommended?	No contact tracing necessary

Scenario 2

	Question	Answer
Screening Results	What symptoms are they showing?	1 high-risk symptom OR ≥ 2 moderate-risk symptoms
	Did they have a COVID-19 Exposure?	No exposure to someone with COVID-19
Actions	Should they be tested?	Yes
	When can they return to School?	<p>If test results are Negative</p> <p>Return to school 24 hours after fever resolution and symptom improvement*</p> <p>OR</p> <p>If the provider believes that an alternate diagnosis is the cause of signs and symptoms, return precautions should be specific to diagnosis</p> <p>*On State recommendation - any negative rapid test must be confirmed by a PCR test before returning to school</p>

		<p>If test results are positive</p> <p>OR</p> <p>No Test</p>	<p>Return to school at least 24 hours since resolution of fever without the use of fever-reducing medications AND improvement in symptoms</p> <p>AND</p> <p>At least 10 days have passed since first symptoms appeared</p>
	Is contact tracing recommended?	<p>Initiate Contact Tracing upon receipt of positive test result</p> <p>These are not probable cases because they lack contact to a confirmed case</p> <p>(epidemiology linkage)</p>	

Scenario 3

	Question	Answer
Screening Results	What symptoms are they showing?	No Symptoms
	Did they have a COVID-19 Exposure?	Yes
Actions	Should they be tested?	Yes, testing recommended between days 5-14 after exposure
	When can they return to School?	<p>If exposure is outside of school OR if in-school without proper mask wearing: Individuals may return after:</p> <ul style="list-style-type: none"> 7 days IF they have NO symptoms and a negative PCR or NAAT test taken after day 5 or 10 days IF they have NO symptoms <p>In both scenarios they must continue to wear their mask and monitor for symptoms for the full 14-day time period. If at any time during that 14-day timeframe, they develop symptoms of COVID-19 they need to isolate and get tested (see scenario 4)</p> <p>If exposure is in-school with proper mask wearing: Individuals do not need to quarantine from school or school activities IF they have NO symptoms, but they must continue to wear their mask and monitor for symptoms for the full 14-day time period. If at any time during that 14-day timeframe, they develop symptoms of COVID-19 they need to isolate and get tested (see scenario 4)</p>

	Is contact tracing recommended?	Initiate Contact Tracing ONLY upon receipt of positive test result

Scenario 4

	Question	Answer	
Screening Results	What symptoms are they showing?	Any moderate or high-risk symptom	
	Did they have a COVID-19 Exposure?	Yes	
Actions	Should they be tested?	Yes	
	When can they return to School?	If test results are positive	Return to school at least 24 hours since resolution of fever without the use of fever-reducing medications and improvement in symptoms AND At least 10 days have passed since first symptoms appeared
		If test results are negative	If the first PCR test is negative, a second negative PCR test will be required for release of isolation prior to the 10 days
	Is contact tracing recommended?	Yes Initiate contact investigation based on symptom onset and exclude contacts until test results are received	If test results are positive
If test results are negative			This will be evaluated on a case by case basis between the school and CCPHC to determine course of action

Infectious Period

Symptomatic Cases: The infectious period is 48 hours before first symptom onset and 1) at least 10 days have passed since symptoms first appeared, 2) at least 24 hours have passed since last fever without the use of fever-reducing medications and, 3) symptoms (e.g., cough, shortness of breath) have improved.

Asymptomatic Cases: The infectious period is calculated from 48 hours before and for 10 days after a positive test based on the **sample collection date**, not the result date.

Close Contact Definition

Once infectious period is established, locate all individuals who meet the close contact or direct contact criteria to the case during that time.

Close Contact:

Anyone who meets any of the following during the infectious period -

- Within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period
- Had direct physical contact (hugging, kissing, tackling, touching, etc.)
- Shared eating or drinking utensils, food, or and other object that had not been sterilized before entering the mouth or nose
- **Exception:** In the **K–12 indoor classroom** setting, the close contact definition **excludes students** who were within **3 to 6 feet of an infected student** (laboratory-confirmed or a [clinically compatible illness](#)) where
 - both students were engaged in **consistent and correct use of well-fitting masks**; **and**
 - other [K–12 school prevention strategies](#) (such as universal and correct mask use, physical distancing, increased ventilation) were in place in the **K–12 school setting**.

This exception **does not** apply to teachers, staff, or other adults in the indoor classroom setting. Mask usage is not factored when determining who is a close contact for adults

Types of Exposure to Consider

- Classroom participants seated within 6 feet in the front, side, and back of confirmed case
- Lunchroom seating area within 6 feet of confirmed case
- Free period interactions with confirmed case
- Transportation seating within 6 feet of confirmed case
- Sport team or extracurricular activities where social distancing is not possible or direct exposure is frequent

Excluding identified Close or Direct Contacts

Once close contacts are identified exclude those individuals based on school policy.

The SARS-CoV-2 incubation period ends 14 days from last contact with a person with confirmed or suspected COVID-19.

- This could be more than 14 days depending if the person with COVID-19 was unable to isolate from the exposed person (e.g. caregiver and child) or if additional exposure with COVID-19 positive persons occurred (e.g. multiple household members).
- Per CDC guidance, a full 14 day quarantine is the preferred option. HOWEVER, if an in-school or school activity exposure occurs and both parties are properly masked, the individual exposed does not need to quarantine from school or school activities. If the exposure occurred out of school or school activities, based on the 12/02/2020 CDC update close contacts may end their

quarantine **after 7 days with a negative PCR or NAAT test taken on or after day 5 or after 10 days** /IF no symptoms have appeared. Close contacts must continue to mask and monitor for symptoms for the full 14 days. If at any time during that 14-day timeframe any moderate or high-risk symptoms develop, the student must isolate and testing is recommended. **NOTE:** If the student or teacher are unable to wear a mask in general or for a particular activity or sport, they would need to complete the 14 day quarantine or avoid any activities for which you cannot wear a mask until the end of the 14 day quarantine.

- Individuals who had a laboratory confirmed COVID-19 illness and fully recovered do NOT need to be quarantined if they are subsequently exposed within the next 3 months and do not have symptoms.
- Individuals who are fully vaccinated against COVID-19 (two weeks from receipt of 2nd dose in a two-dose series or two weeks from receipt of 1st dose of a one-dose series) do NOT need to be quarantined if they are exposed and do not have symptoms.

NOTE: Excluded individuals should be advised to self-monitor using CDC's checklist of signs and symptoms and report the development of any COVID-related symptoms to a healthcare provider.

<https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

3. Send information to Clay County Public Health Center through established reporting methods

Reporting to Clay County Public Health Center

The school and/or school staff may be notified of a COVID-19 positive case prior to the local health department. To eliminate barriers for timely investigations from Clay County Health Center (CCPHC), schools may notify the health center of these occurrences using the online reporting form.

LINK TO REPORTING FORM

https://ccph.iad1.qualtrics.com/jfe/form/SV_4SEXlw1cUiyapsV

Information needed for CCPHC to start the case investigation:

1. Name
2. Date of Birth
3. Home Address
4. Symptom onset date (to the best of your knowledge, will be confirmed upon official case investigation)
5. Testing information (to the best of your knowledge, will be confirmed upon official case investigation)

Please Note: Positive cases living in any county can be reported to CCPHC through this method. CCPHC will conduct the case investigation for all Clay Jurisdiction cases and will route out of jurisdiction cases to the appropriate health department.

Schools may report known exposures/ close contacts through one of 4 options:

- Become users and utilize the CCPHC adopted system to monitor contacts called SARA Alert. Contact the CCPHC school liaison assigned to learn more about this process if interested.
- Submit a "Close Contact Template" to the online report form here:
https://ccph.iad1.qualtrics.com/jfe/form/SV_3DjMXwH1QogkgEB *

- A “Close Contact Template” can also be uploaded into the positives reporting form if this documentation is ready at the time of reporting the positive:
https://ccph.iad1.qualtrics.com/jfe/form/SV_4SEXlw1cUiyapsV *
- A “Close Contact Template” may be emailed to the CCPHC school liaison if the message can be adequately encrypted. If a sender is unsure if their email server has the capability to encrypt emails, please contact IT for your organization. *

*Please email the CCPHC school liaison for a copy of this reporting template

4. When Clay County Public Health Center receives information from the school

Confirmed Cases: Confirmed Cases in CCPHC jurisdiction will be contacted by a Disease Case Investigator (DCI) and entered SaraAlert monitoring system to be monitored for the extent of their isolation.

Close Contacts: This is determined in conjunction with our school liaison

NOTE: If the weekly rate of new cases rises above 200 per 100,000 population, Clay County Public Health MAY NOT be able to conduct contact tracing and MAY NOT be alerting close contacts of their exposure and need to quarantine. Instead, case investigation – the process of connecting with those that have tested positive – will be the focus of health department staff.

School Liaisons

(Please Only Distribute to Internal School Contacts)

North Kansas City and Liberty:

M-F, 8-4:30 - Ryan Shafer: 816-319-8200, rshafer@clayhealth.com

After hours - Elizabeth Yoder: 816-886-8456, eyoder@clayhealth.com

Smithville, Kearney, Excelsior Springs and Private Schools:

M-F, 8-4:30 - DuJuan Hord: 816-702-9427 dhord@clayhealth.com

After hours - Lexi Bertacini: 816-516-7229, abertacini@clayhealth.com

School Liaison Roles

- Be available to assist schools in working through COVID related incidences
- Answer questions from the schools about Clay County Public Health Center school guidance and gating criteria
- Assist schools in monitoring cases or close contacts by linking them to CCPHC’s DCIs
- Send any case or contact information to the proper jurisdiction

CCPHC Resources Outside of the Liaison’s Role

Please route parents or community members to these resources should they have general questions or concerns about COVID.

Scenario	Where to Direct	Contact Information
Parent or community member with questions about CCPHC Interim School Guidance or County Health Orders	CCPHC main line or website	816-595-4200, then press 4 https://www.clayhealth.com/279/COVID-19-2019-Novel-Coronavirus Safe School Reopening Guidance https://www.clayhealth.com/286/Recovery-Guidance
Parent or community member with questions about number of COVID-19 cases at the school or community	To the school dashboard if available or to the CCPHC COVID-19 Hub	https://www.clayhealth.com/288/Local-Data Clay County Public Health Center COVID-19 Hub
Parents or community members with concerns or complaints about school, business, or community guidance	CCPHC mainline or email	816-595-4200, then press 4 Email: Complaints@clayhealth.com
Parents or community members with general questions about COVID-19	Missouri COVID-19 Hotline	877-435-8411 Open 7 days a week; 7 a.m.-9 p.m.
Parents or community members needing resources of any kind	CCPHC website page with list of local resources	https://www.clayhealth.com/283/Resources-for-Residents-Businesses
Information regarding COVID-19 Vaccination	CCPHC Website	https://www.clayhealth.com/301/COVID-19-Vaccine

We will always do our best to connect back with community members that reach out to us for any reason. The situation will dictate who is able to reach out to them and how quickly.

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