



COVID-19 Public Health Recommendations for K-12 Schools, Childcare and Youth Camps

Updated August 29, 2022

This guidance pertains to K-12 schools, preschools, childcare, and youth camps. For this document these settings are collectively described as “schools/ECE.” All guidance herein is applicable to all of these settings, unless otherwise noted. This guidance is based on what is currently known about the transmission and severity of COVID-19 and is subject to change as additional information becomes available. Please check the New Jersey Department of Health (NJDOH) and the Center for Disease Control and Prevention (CDC) websites frequently for updates.

Schools/ECE should put in place a core set of infectious disease prevention strategies as part of their normal operations. The addition and layering of COVID-19-specific prevention strategies should be tied to the CDC’s [COVID-19 Community Levels](#). The following recommendations should be used by local health departments (LHDs) to aid schools/ECE in developing a layered prevention strategy to help prevent the spread of COVID-19. Information specific for overnight camps can be found on CDC’s COVID-19 [Frequently Asked Questions for Directors of Overnight Camps](#) page.

Understanding that COVID-19 may impact certain areas of the state differently, NJDOH shares information on CDC’s COVID-19 community levels at the county level, characterizing community levels as low (green), medium (yellow) and high (orange). The report is posted [online](#) on Fridays and sent out via New Jersey Local Information Network and Communications System ([NJLINCS](#)) to schools/ECE and other public health partners.

Many of the layered prevention strategies described in this document not only protect against COVID-19 spread but can also help prevent the spread of other infectious diseases, such as influenza (flu), respiratory syncytial virus (RSV), and norovirus, thus supporting a healthy learning environment for all. Based on the current phase of the pandemic, available data, and existing prevention measures, the [CDC’s School and ECE guidance](#) focuses on layering prevention strategies. Schools/ECE should implement as many layers as feasible, although the absence of one or more of the strategies outlined in this document does not preclude full-day in-person operations.

To support and prioritize uninterrupted, full-time, in-person learning and care, NJDOH has moved from an individual case-based response strategy to a transmission mitigation strategy, where the risk of the whole school community, including the risk of interruptions to learning, is considered.

[Vaccinations](#), including [booster doses](#) for those eligible, remain the best defense against COVID-19. [Testing](#) and [masking](#) remain key mitigation strategies to detect and decrease transmission of COVID-19.

Schools/ECE may transition away from a case-investigation response model to a routine disease control model. This model focuses more on responding to clusters of cases, outbreaks, and evidence of ongoing transmission in schools/ECE, and less on individual case investigation and contact tracing. A routine disease control model for COVID-19 more closely aligns NJDOH’s COVID-19 mitigation efforts with public health response strategies used for other infectious diseases in schools/ECE.

NJDOH recommends that schools/ECE continue to implement the following COVID-19 prevention and control strategies:

- Encourage students and staff to stay [up to date](#) with vaccination.
- Encourage students and staff to stay home when sick.
- Maintain school policies for reporting positive test results and illness.
- Enforce exclusion for those who are symptomatic or have tested positive for COVID-19 and [other illnesses](#).
- Provide information to parents, students, and staff on prevention strategies including testing and masking following illness and exposure.
- Support mask use by students and staff who choose to mask at any time.
- Implement control measures recommended by LHDs in response to clusters of cases (including increases in respiratory illness) and confirmed outbreaks.
- Continue to report outbreaks and suspected outbreaks immediately to LHDs.
- Follow NJDOH [reporting requirements](#) for reportable diseases.

Outbreaks or newly circulating variants of concern may necessitate more stringent disease control strategies.

Communication

- School officials, childcare and other ECE administrators should maintain close communication with LHDs to provide information and share resources on COVID-19 transmission, prevention, and control measures and to establish procedures for LHD notification and response to COVID-19 illness in school/ECE settings.
- In accordance with [Executive Order 302](#) and [Executive Directive No. 21-011](#), **K-12 schools only** must report weekly student and staff case counts as well as information on student/staff censuses and the total numbers of students/staff fully vaccinated to NJDOH through the Surveillance for Influenza and COVID-19 (SIC) Module in [New Jersey's Communicable Disease Reporting and Surveillance System \(CDRSS\)](#).
- To enroll for reporting in the SIC module, K-12 schools should follow one of the below two options:
 - For existing school users who report ILI/COVID-19 surveillance data into the Communicable Disease Reporting and Surveillance System (CDRSS), nothing additional needs to be done. (Same login at <https://cdrs.doh.state.nj.us/cdrss/login/loginPage>)
 - For schools who aren't current CDRSS users, go to <https://cdrs.doh.state.nj.us/cdrss/login/loginPage> and under "System Announcements" go to "K-12 Module Enrollment and Training" and follow the instructions to enroll to report your school's data. Email CDs.COV.RPT@doh.nj.gov your completed user agreement.

Notification

Because there are still many individuals who remain at risk for severe illness from COVID-19, it continues to be important to alert exposed individuals and/or their parents/guardians so they can make informed

decisions about protecting family and others with whom they might come into contact.

In lieu of individual contact tracing, schools may consider providing cohort [notifications](#) (classroom, cohort, team) when exposures occur. These notifications allow individuals and families to take additional precautions according to their individual needs. Schools and ECE programs can use broad-based notifications to provide timely information via phone, email, or letter to families, students, teachers, caregivers, and staff about potential exposure and the actions they should take to remain safe and reduce transmission. Prompt notification to students and families regarding exposure to infectious diseases, including COVID-19, can allow for rapid testing, early treatment, and prevention of further spread.

Schools/ECE should consider a policy to track individuals who choose to remain at home after potential exposure or known close contact. When a school/ECE is notified of a case, they should [provide instructions](#) to the parent/staff on exclusion and masking recommendations, how to define a close contact and the need to [notify these individuals](#) right away if possible (e.g., older students who can identify and recall close contacts).

Schools/ECE may also consider providing a general notification to the entire school community during times of elevated community transmission of COVID-19. This communication can alert all to the increased potential of being exposed to COVID-19 due to a rise in cases among school and community members and remind all to monitor for symptoms and get tested if they become ill.

Vaccination

COVID-19 vaccination, including booster shots, remains the most critical strategy to prevent severe illness, protect students and staff, and reduce interruptions in learning and care. Schools/ECE are encouraged to speak with their LHD about options for equitable access to vaccines, including on-site or convenient off-site vaccination clinics.

Now that everyone 6 months and older is eligible for COVID-19 vaccine doses, schools/ECE should encourage all students and staff to stay [up to date](#) with their vaccines, which includes [additional doses](#) for individuals who are immunocompromised and [booster doses](#) at regular time points. For the purpose of this document, “up to date” means someone has received all doses in the primary series and all recommended boosters when eligible. Schools/ECE should have a mechanism in place to track “up to date” vaccination status of students and staff and are required to report COVID-19 data into the NJDOH SIC Module in compliance with ED 21-011.

Hand Hygiene and Respiratory Etiquette

Schools/ECE should:

- Teach and reinforce [handwashing](#) with soap and water for at least 20 seconds and increase monitoring of students and staff.
 - If soap and water are not readily available, hand sanitizer that contains at least 60% alcohol can be used (for staff and older children who can safely use hand sanitizer).
- Encourage students and staff to cover coughs and sneezes with a tissue if not wearing a mask.

- Used tissues should be thrown in the trash and hand hygiene as outlined above should be performed immediately.
- Have adequate supplies including soap, hand sanitizer with at least 60% alcohol (for staff and older children who can safely use hand sanitizer), paper towels, tissues, and no-touch trash cans.
- Assist/observe young children to ensure proper handwashing.

Cleaning, Disinfection and Airflow

Schools/ECE should follow standard procedures for routine [cleaning and disinfecting](#) with an [EPA-registered product for use against SARS-CoV-2](#). This means **at least daily** disinfection of surfaces and objects that are touched often, such as desks, countertops, doorknobs, computer keyboards, hands-on learning items, faucet handles, phones and toys.

If there has been a person with COVID-19 compatible symptoms or someone who tested positive for COVID-19 in the facility within the last 24 hours, spaces they occupied should be cleaned and disinfected. Detailed information can be found at CDC’s [Cleaning and Disinfecting Your Facility](#).

Not recommended:

- Alternative surface disinfection methods, such as ultrasonic waves, high intensity UV radiation, and LED blue light. Evidence of effectiveness has not been fully established.
- Sanitizing tunnels. Currently, there is no evidence that sanitizing tunnels are effective in reducing the spread of COVID-19. Chemicals used in sanitizing tunnels could cause skin, eye, or respiratory irritation or injury.
- Fogging, fumigation, and wide-area or electrostatic spraying is not generally recommended as a primary method of surface disinfection and has [several safety risks to consider](#).

Airflow:

Optimizing ventilation and improving [airflow](#) can reduce the risk of germs and contaminants. When COVID-19 Community Levels increase or in response to an outbreak, schools/ECE can take additional steps to increase outdoor air intake and improve air filtration.

Schools/districts are encouraged to review NJDOH’s [Guidance on Air Cleaning Devices for New Jersey Schools](#). See the [NJDOH Environmental Health](#) webpage for [Tips to Improve Indoor Ventilation](#) and [Maintaining Healthy Indoor Air Quality in Public School Buildings](#).

Stay Home When Sick

Educate staff, students, and their families about when they should stay home and when they should return to school/ECE. Schools/ECE should also provide clear and accessible directions to parents/caregivers and students for reporting symptoms and reasons for absences.

Schools/ECE should strictly enforce exclusion criteria for both students and staff. Parents/caregivers should be strongly encouraged to monitor their children for signs and symptoms of illness every day and keep them home if they:

- Have tested positive (viral test) for COVID-19.
- Have symptoms of respiratory or gastrointestinal infections (e.g., cough, fever, sore throat, vomiting, diarrhea).

Testing

When schools/ECE implement testing combined with key mitigation strategies, they can detect new cases to prevent outbreaks, reduce the risk of further transmission, and help protect students, teachers, and staff from COVID-19 and its long-term effects.

In some K-12 schools or ECE programs, school-based healthcare professionals (e.g., school nurses) may perform SARS-CoV-2 antigen testing if they are trained in specimen collection, conducting the test per manufacturer’s instructions, and have obtained a [Clinical Laboratory Improvement Amendments \(CLIA\)](#) certificate of waiver. School-based healthcare professionals may also be able to perform specimen collection to send to a lab for testing, if trained in specimen collection, without having a CLIA certificate. It is important that school-based healthcare professionals have access to, and training on the proper use of, [personal protective equipment \(PPE\)](#) when collecting specimens. (See “Specimen Collection & Handling of Rapid Tests in Point-of-Care Settings” section at [Guidance for SARS-CoV-2 Rapid Testing Performed in Point-of-Care Settings | CDC](#))

Schools/ECE should consider offering over the counter (OTC) self-tests to students and staff who are exposed or symptomatic (see diagnostic and screening sections below).

All laboratories performing COVID-19 testing are required to report all COVID-19 laboratory test results, both positive and negative, electronically to NJDOH. Laboratories are required to report test results into CDRSS. Access to CDRSS requires the completion of training available on the [CDRSS home page](#). Healthcare providers performing point of care (POC) testing, including in K-12 schools, are required to report positive COVID-19 antigen results electronically to NJDOH. Healthcare providers can report into CDRSS or through [SimpleReport](#). Refer to [Guidance for Schools on COVID-19 Reporting Requirements, Reporting Point of Care \(POC\) COVID-19 Test Results, and Screening Testing Program](#). Although reporting negative POC antigen results to NJDOH is no longer required, schools performing screening or other testing may require them, including those from home-based tests.

Testing after a COVID-19 exposure:

Quarantine is no longer recommended for people who are exposed to COVID-19, regardless of vaccination status. Therefore, NJDOH will discontinue its recommendation for a Test to Stay Program. However, asymptomatic students and staff who were exposed to COVID-19 should continue to [test](#) and wear a mask for 10 days. Based on available resources, schools/ECE should provide testing or information on where to obtain equitable and convenient testing after an exposure.

Schools/ECE may also consider offering testing to broader groups of individuals after an exposure (e.g., medically fragile individuals or an identified cohort during an outbreak response).

Diagnostic Testing:

At all [COVID-19 community levels](#), NJDOH recommends that schools/ECE work with their LHDs to identify rapid viral testing options in their community where they can refer ill or exposed students and staff. Access to rapid [COVID-19 testing](#) can reduce unnecessary exclusion of ill persons and their contacts and can reduce disruptions to the educational process. Symptomatic testing may be done using self-tests and/or vendors for schools participating in the grant program (see below).

K-12 Screening testing:

Screening testing identifies people with COVID-19 who do not have symptoms or known or suspected exposures, so that steps can be taken to prevent further spread of COVID-19.

CDC no longer recommends routine screening testing in schools/ECE. However, at a high COVID-19 Community Level, K-12 schools and ECE programs can consider implementing screening testing:

- For students and staff for high-risk activities (e.g., close contact sports, band, choir, theater);
- At key times during the year, for example before/after large events (such as prom, tournaments, group travel); and
- When returning from breaks such as, holidays, spring break, and/or at the beginning of the school year.

In any screening testing program, testing should include both vaccinated and unvaccinated people.

Schools serving students who are at risk for getting very sick with COVID-19, such as those with moderate or severe immunocompromise or complex medical conditions, can consider implementing screening testing at a medium or high COVID-19 Community Level.

Testing strategies in K-12 schools should be developed in consultation with LHDs. Schools and ECE programs that choose to rely on at-home test kits for screening testing should ensure equal access and availability to the tests; establish accessible systems that are in place for ensuring timely reporting of results to the school or ECE program; and communicate with families and staff the importance of remaining at home if they receive a positive test.

Further information on how schools can implement a screening testing program is available in NJDOH screening testing guidelines. K-12 schools interested in participating in this program can obtain additional information by emailing COVID.schooltesting@doh.nj.gov.

In addition to reporting individual test results to public health authorities, K-12 schools must report aggregate screening testing results, including the number of tests performed, directly to NJDOH through the Surveillance for Influenza and COVID-19 (SIC) Module in CDRSS as required in NJDOH Executive Directive 21-011. Registration and training for reporting screening testing data can be found at <https://cdrs.doh.state.nj.us/cdrss/common/cdrssTrainingNotes>.

Home-based testing (self-testing):

COVID-19 self-tests are widely available. While all involve self-collection of specimens, some test kits require a prescription and others are over the counter (OTC). Some collections and/or testing are observed by a telehealth provider, some involve unobserved self-collection but are sent to a laboratory for processing, and others use self-collection and self-testing without any involvement of a healthcare provider. Some home-based tests have been authorized by FDA for screening purposes, others for diagnostic testing. At-home antigen tests have **not** been authorized by the FDA for use in children under 2 years of age. Information on home-based testing is available at https://www.state.nj.us/health/cd/documents/topics/NCOV/COVID_home_tests.pdf.

Testing for COVID-19 with a self-test when symptomatic can provide quick results that allow for timely isolation and contact notification. Self-tests, like all antigen tests, are less sensitive than PCR tests and

self-tests are additionally subject to potential sample collection and testing errors. **If persons are symptomatic (and particularly if they also have been in close contact with someone who has COVID-19), a single negative self-test result should not be considered sufficient to rule-out infection and return to normal activities.** After a negative self-test result, the symptomatic individual should either take a second self-test at least 48 hours after the first one (per manufacturer’s instructions) or seek a test administered by a healthcare provider, either an antigen or a PCR test.

Masks

Wearing a well-fitting mask or respirator consistently and correctly reduces the risk of spreading the virus that causes COVID-19. At a high COVID-19 Community Level, universal indoor masking in schools and ECE programs is recommended, as it is in the community at-large. CDC also recommends masking at all times in healthcare settings, including school nurses’ offices, regardless of the current COVID-19 Community Level.

NJDOH recommends that schools/ECE require masks in the following circumstances:

- **During periods of elevated community levels** – when [COVID-19 Community Levels](#) are high, NJDOH recommends universal masking for all students and staff, especially if there is difficulty incorporating other layered prevention strategies (e.g., adequate ventilation, adequate spacing of students). This would apply to school transportation as well.
 - At a medium or high COVID-19 Community Level, people who are immunocompromised or at risk for getting very sick with COVID-19 should wear a mask or respirator that provides greater protection.
- **During an active outbreak** – during an outbreak or a general increase in cases, schools/ECE should consult with their LHD as to whether short-term universal masking or masking in affected classrooms should be required to control the outbreak/increase in cases.
- **After returning from isolation** – students and staff who return to school after 5 full days of isolation should be required to mask during days 6-10, or until they test negative using two antigen tests collected at least 48 hours apart starting on day 6.
- **After a COVID-19 exposure** – exposed individuals should wear a well-fitting mask for 10 days from last exposure, regardless of vaccination status.
- **When illness occurs in school/ECE** – students or staff who become ill with symptoms consistent with COVID-19 while in school or care should wear a mask until they leave the premises.

During medium or high COVID-19 Community Levels, schools/ECE may consider implementing masking policies for activities or settings where there is increased risk of transmission (e.g., [Sports and High-Risk Activities](#)).

Anyone who chooses to wear a mask or respirator should be supported in their decision to do so at any COVID-19 Community Level, including low. Individuals (including parents/guardians) should make decisions to mask at other times based on their specific situation (e.g., if they or their family members are immunocompromised or at high risk of severe illness from COVID-19) even when school/ECE policies may not require masking.

Detailed information from CDC on mask use can be found at [here](#).

Sports and High-Risk Activities

Due to increased exhalation that occurs during physical activity, some sports can put players, coaches, trainers, and others who are not up to date with vaccinations at [increased risk](#) for getting and spreading COVID-19. Close contact sports and indoor sports are particularly risky for participants and spectators, especially in crowded, indoor venues. Similar risks may exist for other extracurricular activities, such as band, choir, theater, and other school clubs that meet indoors and entail increased exhalation.

At a high COVID-19 Community Level, schools and ECE programs can consider implementing [screening testing](#) for high-risk activities such as indoor sports and extracurricular activities. Schools and ECE programs may consider temporarily stopping these activities to control a school- or program-associated outbreak, or during periods of high COVID-19 Community Levels. ECE programs may also consider layering prevention strategies, such as masking, when close contact occurs, such as during feeding and diapering young children and infants.

In general, the risk of COVID-19 transmission is lower when playing outdoors than in indoor settings. Coaches and school sports administrators should also consider [specific sport-related risks](#) when developing prevention strategies.

When directed by the appropriate health agency or officer to institute remote learning or a public health-related closure due to a current outbreak, NJDOH recommends postponing extracurricular activities involving mixing of cohorts (e.g., school sport practices and competitions, clubs, assemblies). If a school/ECE has an active outbreak of COVID-19 but remains open for in-person instruction and/or care, in consultation with the LHD and based on the public health investigation, some or all school extracurricular activities may need to be postponed until the outbreak is concluded.

Response to Symptomatic Students and Staff

Schools/ECE should ensure that procedures are in place to identify and respond to a student or staff member who exhibits COVID-19 symptoms.

- Closely monitor daily reports of staff and student attendance/absence and identify when persons are out with COVID-19 symptoms.
- Designate an area or room away from others to isolate individuals who exhibit COVID-19 symptoms while at school/ECE.
 - Consider an area separate from the nurse's office so the nurse's office can be used for routine visits such as medication administration, injuries, and non-COVID-19 related visits.
 - Ensure that the symptomatic individual wears a mask if possible. If they cannot wear a mask, they should be separated from others as much as possible; children should be supervised by a designated caregiver who is wearing a well-fitting mask or respirator until they leave school grounds.
 - Ensure that hygiene supplies are available, including additional masks, facial tissues, and hand sanitizer that contains at least 60% alcohol.
 - School nurses should use [Standard and Transmission-Based Precautions](#) based on the [care and tasks](#) required.

- Follow CDC guidance for [Cleaning and Disinfecting Your Facility](#).

When illness occurs in the school/ECE setting

Children and staff with COVID-19 symptoms regardless of vaccination or previous infection status should be separated away from others until they can be sent home.

- If a mask cannot be worn by the symptomatic individual, other staff should be sure to mask. Ask the ill student (or parent) and staff whether they have had potential exposure to COVID-19 meeting the definition of a [close contact](#).
- Symptomatic individuals should be sent home. Persons with [COVID-19-compatible symptoms](#) should undergo COVID-19 testing regardless of vaccination status.
 - If COVID-19 [community level is low](#), symptomatic individuals **without potential exposure to COVID-19** should use the [NJDOH School Exclusion List](#) to determine when they may return to school/ECE. No public health notification is needed UNLESS there is an unusual increase in the number of persons who are ill (over normal levels), such as classroom or cohort clusters, which might indicate an outbreak.
 - If [community level is medium or high](#), symptomatic individuals should continue to be excluded according to the COVID-19 Exclusion Criteria (see below).

Regardless of vaccination or previous infection status, if a student or staff experiences [COVID-compatible symptoms](#), they should be isolated [from others](#), be clinically evaluated for COVID-19, and tested for SARS-CoV-2.

Exclusion

Parents should not send students to school/ECE when sick, and symptomatic staff should not come to work.

For school/ECE settings, NJDOH recommends that students/staff with the following COVID-19 compatible symptoms be promptly isolated from others and excluded from school/ECE:

- At least **two** of the following symptoms: fever (measure or subjective), chills, rigors (shivers), myalgia (muscle aches), headache, sore throat, nausea or vomiting, diarrhea, fatigue, congestion or runny nose; **OR**
- At least **one** of the following symptoms: new or worsening cough, shortness of breath, difficulty breathing, new olfactory disorder, new taste disorder.

For students with chronic illness, only new symptoms, or symptoms worse than baseline should be used to fulfill symptom-based exclusion criteria.

COVID-19 exclusion (isolation) criteria for individuals who have COVID-19 compatible symptoms or who test positive for COVID-19:

Individuals regardless of vaccination status who test positive, and individuals with COVID-19 symptoms who have not been tested and do not have an alternative diagnosis from their healthcare provider should:

- Stay home for at least 5 full days after the onset of symptoms or if asymptomatic after the positive test (day of symptoms is day 0; if asymptomatic, day the test was performed is day 0) AND
- If they have no symptoms or symptoms are resolving after 5 days and are fever-free (without the use of fever-reducing medication) for 24 hours, they can return to school AND:
 - Wear a mask when around others at home and in public for an additional 5 days (including participation in any extracurricular activities). Time without mask being worn should be kept to a minimum.

Exception: During periods of low community transmission (green), students and staff with COVID-19 compatible symptoms who are not tested **and do not have a known COVID-19 exposure** may follow the [NJDOH School Exclusion List](#) to determine when they may return to school/ECE.

CDC recommends an isolation period of at least 10 and up to 20 days for people who were severely ill with COVID-19 and for [people with weakened immune systems](#). See [Overview of COVID-19 Isolation for K-12 Schools](#) for additional details. Individuals should contact their HCP to determine when they can be around others.

Individuals with an alternative diagnosis:

Evaluation by a health care provider may be necessary to differentiate between COVID-19 and alternative diagnoses. Clinical evaluation and/or testing for COVID-19 may be considered for ANY of the symptoms listed above, depending on suspicion of illness from a health care provider. Testing is strongly recommended, especially when there are multiple unlinked cases in the school/ECE and during periods of medium and high COVID-19 Community Levels.

During medium and high community levels, individuals with COVID-19 compatible symptoms and no known exposure to a COVID-19 case in the last 5 days, regardless of vaccination status, may follow the [NJDOH School Exclusion List](#) to determine when they may return to school/ECE only if they have an alternative diagnosis (e.g., strep throat, influenza, worsening of chronic illness) supported by clinical evaluation.

The information below can be used to determine the need for and duration of exclusion. To facilitate rapid diagnosis and limit unnecessary school exclusion, schools/ECE may consider implementing school-based [diagnostic testing](#) for students and staff.

Response to Exposed Students and Staff

Close contact is defined as being within 6 feet of someone with suspected or known COVID-19 for 15 or more minutes during a 24-hour period. In certain situations, it may be difficult to determine whether individuals have met this criterion and an entire cohort, classroom, or other group may need to be considered exposed.

Individuals would be considered exposed to someone with COVID-19 from 2 days prior to symptom onset (or positive test date if asymptomatic) to 5 days after onset (not during the case's additional precaution period at day 6-10).

Quarantine is no longer recommended for people who are exposed to COVID-19 except in certain high-risk congregate settings. In schools and ECE settings, which are generally not considered high-risk congregate settings, people who were exposed to COVID-19 can continue to attend school as long as they remain asymptomatic. CDC recommends that individuals who were exposed to COVID-19 wear a well-fitting mask for 10 days after exposure.

Exposed persons, regardless of vaccination status, are strongly recommended to get tested 5 full days after exposure, on day 6 (date of exposure is considered day 0). If testing is unavailable, school attendance can continue. If the test is positive, they must follow isolation recommendations.

If the exposed individual has had COVID-19 within the past 90 days, see [specific testing recommendations](#).

After an exposure, students/parents and staff should carefully monitor for fever (100.4°F or greater), cough, shortness of breath, or other COVID-19 symptoms for 10 days. If COVID-19 symptoms develop, students/staff should immediately get tested and follow isolation recommendations.

Note: The inability to consistently and correctly wear a mask due to intellectual, developmental, or physical disability or medical contraindications alone should not be a basis for disallowing a return to school activities. Schools should assess, on an individualized basis, the appropriate accommodations for students with disabilities who are unable to wear a mask, taking into consideration the following:

- The level of risk of the exposure (e.g., ongoing household exposure imposes a higher risk than exposure within six feet of distance or classroom exposure).
- The feasibility of conducting testing during the 5 days after exposure (at least immediately and on day 6).
- Whether there are individuals in the classroom who are known to be at high risk for severe disease.
- The individual's vaccination status.
- Other mitigation measures in place (e.g., ventilation, distancing) and whether they can be strengthened or are already optimized.
- Circumstances of the child's learning and school attendance needs (e.g., cannot participate in remote instruction).

If a child under 2 years of age (unable to mask) is exposed, programs should implement alternative measures including daily symptom monitoring by parents as well as the program and enforcing mask use for individuals 2 years of age or older (staff and students) who care for or come in contact with the exposed child.

In specific circumstances where the student population may be at risk for getting very sick with COVID-19, schools may opt to follow [isolation and quarantine](#) guidance for high-risk congregate settings, which includes recommendations of a 10-day period for isolation and quarantine.

- Schools and ECE programs should balance the potential benefits of following that guidance with the impact these actions would have on student well-being, such as the ability to participate in in-person instruction, food service access, and social interaction.
- Schools with students at risk for severe illness due to COVID-19 should make reasonable modifications when necessary to ensure that all students, including those with disabilities, are able to access in-person learning such as implementing additional layers of prevention strategies (e.g., masking, testing and symptom monitoring).
- Individuals who are at increased risk for severe illness should contact their HCP about additional precautions that may be necessary.

Outbreaks

Schools/ECE must report outbreaks or suspected outbreaks of all communicable diseases, including COVID-19 to their LHD. The LHD will work with schools/ECE to determine if there is an outbreak and provide guidance as to a response. An outbreak of COVID-19 in a school/ECE setting is defined as three or more individuals (positive by RT-PCR or antigen) among students or staff with illness onsets within a 14-day period, who are epidemiologically linked¹, do not share a household, and were not identified as close contacts of each other in another setting during standard case investigation or contact tracing.

Schools/ECE should be prepared to provide the following information when consulting with the LHD:

- Contact information for the symptomatic individuals.
- The date the individual(s) developed symptoms, tested positive for COVID-19 (if known), and was last in the building.
- Types of interactions (close contacts, length of contact) the person(s) may have had with other persons in the building or in other locations.
- Vaccination status of those with symptoms and the close contacts.
- Names, addresses, and telephone numbers for the symptomatic person's close contacts in the school/ECE;
- Any other information to assist with the determination of next steps.

If an outbreak has been identified, schools/ECE and LHDs should promptly intervene to control spread while working to determine whether the outbreak originated in the school setting. In instances of a cluster of cases, an outbreak or evidence of ongoing transmission in schools/ECE, schools/ECE may want to consider additional mitigation strategies. These may include:

- Testing for symptomatic persons, close contacts, impacted cohorts/groups, higher risk activities, or students at risk for severe illness.
- Schools/ECE should work with their local health department to determine if testing should be used at the classroom, grade, or school level.
- Temporary transition to universal masking or masking in affected classrooms.
- Case investigation and contact tracing.

¹ Health departments should verify to the best extent possible that cases were present in the same setting during the same time period (e.g., same classroom, school event, school-based extracurricular activity, school transportation) within 14 days prior to onset date (if symptomatic) or specimen collection date for the first specimen that tested positive (if asymptomatic or onset date is unknown) and that there is no other more likely source of exposure (e.g., household or close contact to a confirmed case outside of educational setting).

- Temporary suspension and/or reorganization (e.g., moving outdoors) of higher risk activities.
- Temporary transition to remote learning. K-12 Schools, when directed by the appropriate health agency or officer to institute a public health-related closure, may temporarily transition affected cohorts to remote learning if a high number of cases is preventing timely notification and exclusion and a short-term transition to remote learning is needed to allow for such actions to occur.

Decisions to implement testing programs and/or transition cohorts to remote learning should be made by schools/ECE based on their individual circumstances in conjunction with LHDs.

Resources

CDC

- [Operational Guidance for K-12 Schools and Early Care and Education Programs to Support Safe In-Person Learning](#) Updated August 11, 2022
- [Frequently Asked Questions for Directors of Overnight Camps](#) May 27, 2022
- [Interactive School Ventilation Tool](#) May 27, 2022
- [Stay Up to Date with Your Vaccines](#) July 19, 2022
- [Isolation and Precautions for People with COVID-19](#) August 11, 2022
- [School and Childcare Programs](#) August 11, 2022
- [CDC Cleaning and Disinfecting Your Facility](#) November 15, 2021
- [Multisystem Inflammatory Syndrome \(MIS-C\)](#)
- [Science Brief: Indicators for Monitoring COVID-19 Community Levels and Making Public Health Recommendations](#) August 11, 2022

NJDOH

- [NJDOH COVID Information for Schools](#)
- [Maintaining Healthy Indoor Air Quality in Public School Buildings](#)
- [NJDOH Disinfectant Use in Schools Fact Sheet](#)
- [NJDOH General Guidelines for the Prevention and Control of Outbreaks in School Settings](#)
- [New Jersey COVID-19 Information Hub](#)

OTHER RESOURCES

- [COVID-19 Planning Considerations: Guidance for School Re-entry, American Academy of Pediatrics](#)
- [Healthy Children.Org COVID-19](#)

Sample COVID-19 School Exposure Notification Template

[DATE]

Dear Parent/Guardian,

This letter is to inform you that an individual in [SCHOOL/CHILDCARE/CLASS/CAMP] has tested positive for COVID-19 on ___/___/_____ and your child may have been exposed.

ACTIONS TO TAKE:

We encourage you to watch for any symptoms of COVID-19 in your child for the next 10 days, through [10 DAYS SINCE EXPOSURE]. If your child develops any symptoms of COVID-19, please notify [NAME AND CONTACT INFORMATION FOR POINT OF CONTACT FOR SCHOOL/CHILDCARE/CAMP], contact your child's doctor for evaluation and/or testing, and keep your child home from school, childcare, and activities.

Symptoms could include any of the following:

- Fever of 100.4°F / 38°C or higher
- New or worsening cough
- Shortness of breath/difficulty breathing
- Chills
- Fatigue
- Muscle pain or body aches
- New taste or smell disorder
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea
- Headache

Students and staff, regardless of vaccination status, who are identified as *close contacts or who may have been exposed, may continue to attend school/ECE **as long as they remain symptom free and wear a mask while at school for 10 days following exposure**. Testing is strongly encouraged 5 days after the potential exposure date.

Based on the individual needs of your family, you may choose to have your child follow traditional quarantine and remain at home for 5 days, returning to school on day 6 [DATE] **if they remain symptom free**.

If your child tests positive for COVID-19 test result, even if asymptomatic, please keep your child home from school, activities, camp and childcare for at least 5 days and notify [NAME AND CONTACT INFORMATION FOR POINT OF CONTACT FOR SCHOOL/CHILDCARE/CAMP]. Please feel free to contact us with any questions.

Thank you,

[NAME OF PERSON SIGNING LETTER]

*Close contact: A close contact is someone who was exposed to a person with COVID-19 infection. A close contact is generally defined as someone who was within 6 feet of a COVID-19 case for 15 cumulative minutes or more over a 24-hour period of time during the case's infectious period.

Sample COVID-19 School Positive Student Template

[DATE]

Dear Parent/Guardian,

This letter is regarding your child's recent positive COVID-19 test result. Please note the following recommendations for individuals who have tested positive for COVID-19, regardless of symptoms:

- **ISOLATE:** Your child should isolate (separate from others) at home for at least five full days from when they began experiencing symptoms and avoid being around others as much as possible. Be sure to keep your child home from school, childcare, and extra-curricular activities/sports.
 - The day symptoms began considered Day 0.
 - If your child was asymptomatic (did not develop symptoms), Day 0 is the date the COVID-19 test was taken.
- **MASK:** Your child should wear a well-fitting mask whenever around others through Day 10.
- **MONITOR:** Monitor your child's symptoms and call your medical provider for worsening illness and for any other symptoms that seem severe or are concerning to you.
- **RETURN TO [SCHOOL/CHILDCARE/CAMP]:** Your child may return to [SCHOOL/CHILDCARE/CAMP] on Day 6 [DATE] if:
 - They have been fever free for 24 hours without the use of fever-reducing medications; and
 - Other symptoms of COVID-19 are improving.
 - A well-fitting mask can be worn through Day 10

Participation in extracurricular activities (sports, clubs, chorus, etc.) will be limited to only those activities where masks can be worn consistently and correctly.

You are urged to speak with your child about anyone they may have been in *close contact with during the 2 days PRIOR to the start of symptoms through Day 5, or for those who did not develop symptoms, from the date the test was taken through Day 5.

In order to help slow the transmission of illness to others, you are urged to notify the parents/guardians (if known) of any students your child identifies as having been a close contact. The close contact (or parent) should monitor for symptoms for 10 days after last contact with your child and wear a well-fitting mask and get tested for COVID-19 at least 5 full days after exposure, on day 6. If you have any questions, please contact [NAME AND CONTACT INFORMATION FOR POINT OF CONTACT FOR SCHOOL/CHILDCARE/CAMP].

Thank you,

[NAME OF PERSON SIGNING LETTER]

*Close contact: A close contact is someone who was exposed to a person with COVID-19 infection. A close contact is generally defined as someone who was within 6 feet of a COVID-19 case for 15 cumulative minutes or more over a 24-hour period of time during the case's infectious period.