

Revised Public Health Guidance for Schools

PART 5 — SUPPORTING THE FULL RETURN TO
IN-PERSON LEARNING FOR ALL STUDENTS
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Executive Summary

In-person learning with the appropriate protective measures should be both safe and essential to students' mental health and academic growth. In its [scientific brief on transmission of SARS-CoV-2 in K-12 schools](#), the Centers for Disease Control and Prevention (CDC) cites several sources that suggest lower prevalence of disease, susceptibility, and transmission in children – especially those under the age of 10 – although additional studies are needed to further understand this finding. Further, the authors cite recent studies documenting that, with prevention strategies in place, in-person learning was not associated with higher levels of transmission when compared to communities without in-person learning.^{1 2 3}

The majority of students need full-time in-person access to their teachers and support network at school to stay engaged, to learn effectively, and to maintain social-emotional wellness. A recent study from the CDC⁴ suggests that remote learning can be challenging for many students, leading not only to learning loss, but also worsening mental health for children as well as parents. CDC found that students of color were more likely to miss out on in-person learning: nationwide, in April, only 59 percent of Hispanic students, 63 percent of Black students, and 75 percent of White students had access to full-time in-person school. Restoring full-time in-person

¹ National Academies of Sciences, Engineering, and Medicine. (2020). *Reopening K-12 schools during the COVID-19 pandemic: Prioritizing health, equity, and communities*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25858>

² Donohue, J. M., & Miller, E. (2020, July 29). COVID-19 and school closures. *JAMA*, 324(9), 845-847. <https://doi.org/10.1001/jama.2020.13092>

³ Russell, F. M., Ryan, K., Snow, K., Danchin, M., Mulholland, K., & Goldfeld, S. (2020, September 25). *COVID-19 in Victorian schools: An analysis of child-care and school outbreak data and evidence-based recommendations for opening schools and keeping them open*. Melbourne, Australia: Murdoch Children's Research Institute and the University of Melbourne. Retrieved from https://issuu.com/murdochchildrens/docs/covid-19_in_victorian_schools_report_1

⁴ Oster, E., Jack, R., Halloran, C., Schoof, J., McLeod, D., Yang, H., Roche, J., & Roche, D. (2021, June 29). Disparities in learning mode access among K-12 students during the COVID-19 pandemic, by race/ethnicity, geography, and grade level – United States, September 2020-April 2021. *Morbidity and Mortality Weekly Report*, 70. <http://dx.doi.org/10.15585/mmwr.mm7026e2>

learning for all students is essential to our state’s commitment to educational equity.

Please note that additional studies are needed to better understand transmission in all populations. Specifically, there are risks of transmission in schools and adult populations (teachers, school staff, parents) continue to be at risk of transmission when in-person learning is resumed. While most COVID-19-associated hospitalizations occur in adults, severe disease occurs in all age groups, including adolescents aged 12 to 17 years, who were hospitalized at a rate of 49.9 per 100,000 from March 2020 to April 2021.⁵ As the Delta variant becomes more common across the United States, including in Illinois, the greatest risk for infection and severe complications is among people **who are not fully vaccinated**, including children younger than 12 years old who are not yet eligible for the COVID-19 vaccine. For example, recent evidence from the United Kingdom, where the highly transmissible variant⁶ is already widespread, found five times higher rates of infection among children aged 5 to 12 years and young adults aged 18 to 24 years compared to those aged 65 years and older, with the majority of infections in the younger group occurring among the unvaccinated.^{7 8}

⁵ Havers, F. P., Whitaker, M., Self, J. L., Chai, S. J., Kirley, P. D., Alden, N. B., Kawasaki, B., Meek, J., Yousey-Hindes, K., Anderson, E. J., Openo, K. P., Weigel, A., Teno, K., Monroe, M. L., Ryan, P. A., Reeg, L., Kohrman, A., Lynfield, R., Como-Sabetti, K., ... COVID-NET Surveillance Team. (2021, June 11). Hospitalization of adolescents aged 12-17 years with laboratory-confirmed COVID-19 – COVID-NET, 14 states, March 1, 2020-April 24, 2021. *Morbidity and Mortality Weekly Report*, 70(23), 851-857. <http://dx.doi.org/10.15585/mmwr.mm7023e1>

⁶ Allen, H., Vusirikala, A., Flannagan, J., Twohig, K. A., Zaidi, A., COG-UK Consortium, Groves, N., Lopez-Bernal, J., Harris, R., Charlett, A., Dabrera, G., & Kall, M. (2021). Increased household transmission of COVID-19 cases associated with SARS-CoV-2 variant of concern B.1.617.2: A national case-control study. Retrieved from <https://khub.net/documents/135939561/405676950/Increased+Household+Transmission+of+COVID-19+Cases+-+national+case+study.pdf/7f7764fb-ecb0-da31-77b3-b1a8ef7be9aa>

⁷ Riley, S., Wang, H., Eales, O., Haw, D., Walters, C., Ainslie, K., Atchison, C., Fronterre, C., Diggle, P., Page, A., Prosolek, S., Trotter, A. J., Le Viet, T., Alikhan, N., COG-UK Consortium, Ashby, D., Donnelly, C., Cooke, G., Barclay, W., Ward, H., Darzi, A., & Elliott, P. (2021). *REACT-1 round 12 report: Resurgence of SARS-CoV-2 infections in England associated with increased frequency of the Delta variant* [working paper]. London, UK: Imperial College London. Retrieved from <http://hdl.handle.net/10044/1/89629>

⁸ For the purposes of this joint guidance, the term “unvaccinated” means a person not fully vaccinated against SARS-CoV-2, the virus that causes COVID-19.

Vaccination is currently the leading public health prevention strategy to end the COVID-19 pandemic. People who are fully vaccinated against COVID-19 are at low risk of symptomatic or severe infection. A [growing body of evidence](#) suggests that people who are fully vaccinated against COVID-19 are less likely to have an asymptomatic infection or transmit COVID-19 to others than people who are not fully vaccinated. In most settings, people who are [fully vaccinated](#) can safely resume activities they did before the pandemic, except where prevention measures are required by federal, state, local, tribal, or territorial laws, rules, and regulations, including local business and workplace guidance.

Immunization of P-12 teachers in Illinois began in February 2021 with much success protecting school staff from COVID-19. Research in real-world conditions found the two-dose COVID-19 vaccine series to be 90% effective against infection.⁹ In April 2021, all Illinoisans age 16 and older became eligible for vaccination, followed by [12- to 15-year-old individuals](#) in May 2021. Schools can [promote vaccinations](#) among teachers, staff, families, and eligible students by providing information about COVID-19 vaccination, encouraging vaccine trust and confidence, and establishing supportive policies and practices that make getting vaccinated as easy and convenient as possible.

As the newer, more transmissible Delta variant becomes more common across the U.S., and following the release of updated [CDC guidance for K-12 schools](#), this joint guidance from the Illinois Department of Public Health (IDPH) and the Illinois State Board of Education (ISBE) makes important updates to the essential, layered mitigation strategies that facilitate the safe return to full-time in-person instruction beginning with the start of the 2021-22 school year. IDPH is issuing this guidance under its broad authority to protect the public health¹⁰ in an effort

⁹ Thompson, M. G., Burgess, J. L., Naleway, A. L., Tyner, H. L., Yoon, S. K., Meece, J., Olsho, L. E. W., Caban-Martinez, A. J., Fowlkes, A., Lutrick, K., Kuntz, J. L., Dunnigan, K., Odean, M. J., Hegmann, K. T., Stefanski, E., Edwards, L. J., Schaefer-Solle, N., Grant, L., Ellingson, K., Groom, H. C. ... Gaglani, M. (2021, April 2). Interim estimates of vaccine effectiveness of BNT162b2 and mRNA-1273 COVID-19 vaccines in preventing SARS-CoV-2 infection among health care personnel, first responders, and other essential and frontline workers – Eight U.S. locations, December 2020-March 2021. *Morbidity and Mortality Weekly Report*, 70(13), 495-500. <https://dx.doi.org/10.15585/mmwr.mm7013e3>

¹⁰ The Department of Public Health Act, 20 ILCS 2305.

to restrict and suppress the continued spread of COVID-19 and allow students across Illinois to safely and fully return to the in-person learning conditions that they need to thrive. Students in Illinois and across the country returned safely to in-person learning throughout the 2020-21 school year with limited transmission occurring in school facilities due to students' and teachers' adherence to public health requirements. This guidance reflects what we have learned about preventing the transmission of COVID-19 in school settings, incorporates the efficacy of the vaccine, accounts for widespread availability of COVID-19 testing and the increasing number of students and educators who are fully vaccinated,¹¹ and aligns with the updated [guidance for COVID-19 prevention in K-12 schools](#) issued by the CDC on July 9, 2021, and updated on July 27, 2021.

This guidance supports the safe and full return to in-person instruction for the 2021-22 school year, as declared by State Superintendent of Education, Dr. Carmen I. Ayala, on July 9, 2021:

Beginning with the 2021-22 school year, all schools must resume fully in-person learning for all student attendance days, provided that, pursuant to [105 ILCS 5/10-30](#) and [105 ILCS 5/34-18.66](#), remote instruction be made available for students who have not received a COVID-19 vaccine or who are not eligible for a COVID-19 vaccine, only while they are under quarantine consistent with guidance or requirements from a local public health department or the Illinois Department of Public Health.¹²

The State of Illinois has adopted the CDC's updated guidance regarding COVID-19 prevention in K-12 schools. Based on that guidance and related updates on July 27, 2021, ISBE and IDPH have updated the public health requirements for schools and associated guidance in these guidelines. This guidance applies to all public and nonpublic schools that serve students in prekindergarten through grade 12 (P-12).

Public Health Requirements for Schools

The following guidance is based on updated CDC guidance for COVID-19 prevention in K-12 schools and the State of Illinois updated Executive Order. [Executive Order 2021-18](#) requires that masks be worn indoors by all teachers, staff, students, and visitors to P-12 schools, regardless of

¹¹ People are considered fully vaccinated against COVID-19 two weeks after their second dose in a two-dose series (e.g., Pfizer or Moderna) or two weeks after a single-dose vaccine (e.g., Johnson & Johnson's Janssen). For more information, see CDC guidance at <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html#vaccinated>.

¹² Illinois Department of Public Health. (2021, July 9). *Illinois Department of Public Health adopts CDC COVID-19 prevention school guidance* [News release]. Retrieved from https://www2.illinois.gov/IISNews/23550-IDPH_Adopts_CDC_COVID-19_Prevention_School_Guidance.pdf

vaccination status. The State of Illinois also requires all public and nonpublic schools to comply with contact tracing, in combination with isolation and quarantine, as directed by state and local public health departments.

In addition to requirements for consistent and correct universal indoor mask use and contact tracing, isolation, and quarantine, the following COVID-19 prevention strategies, as outlined in this guidance, remain critical to protect students, teachers, and staff who are not fully vaccinated, especially in areas of moderate to high community transmission levels, and to safely deliver in-person instruction. Schools must implement these other layered prevention strategies to the greatest extent possible and taking into consideration factors such as community transmission, vaccination coverage, screening testing, and occurrence of outbreaks, consistent with CDC guidance.

1. Promote and/or provide COVID-19 immunization for all eligible staff and students.
2. Facilitate physical distancing. Schools should configure their spaces to provide space for physical distancing to the extent possible in their facilities.
3. Implement or provide provisions for SARS-CoV-2 testing for diagnostic testing for suspected cases, close contacts, and during outbreaks, as well as screening testing for unvaccinated staff and students according to the CDC's testing recommendations.
4. Improve ventilation to reduce the concentration of potentially virus-containing droplets in schools' indoor air environments.
5. Promote and adhere to hand hygiene and respiratory etiquette.
6. Encourage individuals who are sick to stay home and get tested for COVID-19.
7. Clean and disinfect surfaces in schools to maintain healthy environments.

It is important to note that these requirements are subject to change pursuant to changing public health conditions and subsequent updated public health guidance, including from the CDC.

IDPH Health and Safety Requirements

Districts and schools should proactively prepare staff and students to prevent the spread of COVID-19 and any other infectious disease. All employees should be trained on health and safety protocols related to COVID-19.

- 1. Promote and/or provide COVID-19 immunization for all eligible staff and students.**

COVID-19 vaccines are [safe](#) and [effective](#).^{13 14 15} The [CDC scientific brief on COVID-19 vaccines and vaccination](#) cites research in clinical trials and real-world settings documenting that vaccination in adults and children as young as 12 years old reduces the chances of contracting the virus that causes COVID-19, including several variants. The CDC also cites evidence that fully vaccinated people are less likely to have asymptomatic infection or transmit SARS-CoV-2 to others. Importantly, the evidence also suggests that the COVID-19 vaccine is highly effective at reducing odds for severe complications, hospitalizations, and death.^{16 17 18}

At this time, there are limited data on vaccine protection in people who are immunocompromised. Fully vaccinated persons with immunocompromising conditions,

¹³ Tenforde, M. W., Olson, S. M., Self, W. H., Talbot, H. K., Lindsell, C. J., Steingrub, J. S., Shapiro, N. I., Ginde, A. A., Douin, D. J., Prekker, M. E., Brown, S. M., Peltan, I D., Gong, M. N., Mohamed, A., Khan, A., Exline, M. C., Files, D. C., Gibbs, K. W., Stubblefield, W. B., ... HAIVEN Investigators. (2021, May 7). Effectiveness of Pfizer-BioNTech and Moderna vaccines against COVID-19 among hospitalized adults aged ≥65 years – United States, January-March 2021. *Morbidity and Mortality Weekly Report*, 70(18), 674-679. <http://dx.doi.org/10.15585/mmwr.mm7018e1>

¹⁴ Thompson, M. G., Burgess, J. L., Naleway, A. L., Tyner, H. L., Yoon, S. K., Meece, J., Olsho, L. E. W., Caban-Martinez, A. J., Fowlkes, A., Lutrick, K., Kuntz, J. L., Dunnigan, K., Odean, M. J., Hegmann, K. T., Stefanski, E., Edwards, L. J., Schaefer-Solle, N., Grant, L., Ellingson, K., Groom, H. C. ... Gaglani, M. (2021, April 2). Interim estimates of vaccine effectiveness of BNT162b2 and mRNA-1273 COVID-19 vaccines in preventing SARS-CoV-2 infection among health care personnel, first responders, and other essential and frontline workers – Eight U.S. locations, December 2020-March 2021. *Morbidity and Mortality Weekly Report*, 70(13), 495-500. <https://dx.doi.org/10.15585/mmwr.mm7013e3>

¹⁵ Britton, A., Jacobs Slifka, K. M., Edens, C., Nanduri, S. A., Bart, S. M., Shang, N., Harizaj, A., Armstrong, J., Xu, K., Ehrlich, H. Y., Soda, E., Derado, G., Verani, J. R., Schrag, S. J., Jerniga, J. A., Leung, V. H., & Parikh, S. (2021, March 19). Effectiveness of the Pfizer-BioNTech COVID-19 vaccine among residents of two skilled nursing facilities experiencing COVID-19 outbreaks – Connecticut, December 2020-February 2021. *Morbidity and Mortality Weekly Report*, 70(11), 396-401. <http://dx.doi.org/10.15585/mmwr.mm7011e3>

¹⁶ Christie, A., Henley, S. J., Mattocks, L., Fernando, R., Lansky, A., Ahmad, F. B., Adjemian, J., Anderson, R. N., Binder, A. M., Carey, K., Dee, D. L., Dias, T., Duck, W. M., Gaughan, D. M., Lyons, B. C., McNaghten, A. D., Park, M. M., Reses, H., Rodgers, L., ... Beach, M. J. (2021, June 11). Decreases in COVID-19 cases, emergency department visits, hospital admissions, and deaths among older adults following the introduction of COVID-19 vaccine – United States, September 6, 2020-May 1, 2021. *Morbidity and Mortality Weekly Report*, 70(23), 858-864. <http://dx.doi.org/10.15585/mmwr.mm7023e2>

¹⁷ Haas, E. J., Angulo, F. J., McLaughlin, J. M., Anis, E., Singer, S. R., Khan, F., Brooks, N., Smaja, M., Mircus, G., Pan, K., Southern, J., Swerdlow, D. L., Jodar, L., Levy, Y., Alroy-Preis, S. (2021). Impact and effectiveness of mRNA BNT162b2 vaccine against SARS-CoV-2 infections and COVID-19 cases, hospitalisations, and deaths following a nationwide vaccination campaign in Israel: An observational study using national surveillance data. *The Lancet*, 397(10287), 1819-1829. [https://doi.org/10.1016/S0140-6736\(21\)00947-8](https://doi.org/10.1016/S0140-6736(21)00947-8)

¹⁸ Lavista Ferres, J. M., Richardson, B. A., & Weeks, W. B. (2021). Association of COVID-19 vaccination prioritization and hospitalization among older Washingtonians. *Journal of the American Geriatrics Society*. <https://doi.org/10.1111/jgs.17315>

including those taking immunosuppressive medications (e.g., drugs such as mycophenolate or rituximab to suppress rejection of transplanted organs or to treat rheumatologic conditions), should discuss the need for personal protective measures with their health care provider after vaccination.

Promoting and/or providing vaccination for students, staff, and teachers is a primary way to protect staff and students and to slow the spread of COVID-19. Strategies that minimize barriers to access vaccination for teachers and other frontline workers, such as vaccine clinics at or close to the place of work, are optimal. School officials and local health departments should work together to support messaging and outreach regarding vaccination for members of school communities, including students under 12 years old as they become eligible for vaccination in their jurisdictions. For more information, see [IDPH's answers to frequently asked questions \(FAQs\) about COVID-19 vaccination for young people](#).

ISBE and IDPH have provided the following resources to support school districts in hosting vaccination events or communicating with school communities about other options for eligible children and families to receive the COVID-19 vaccine.

- [Hosting a Vaccination Event](#): Contact information and instructions for reaching out to a community vaccine provider in the event that your district can host a vaccination event at one or more schools.
- [Parent Letter](#): Letter to send to parents and families on either IDPH and ISBE letterhead or district letterhead to communicate about options for eligible children to receive the COVID-19 vaccine if your district does not host a vaccination event.
 - [Arabic](#)
 - [Chinese Simplified](#)
 - [Chinese Traditional](#)
 - [Polish](#)
 - [Tagalog](#)
 - [Urdu](#)
 - [Spanish](#)
- [Strategies to Build Vaccine Confidence](#)
- [How to Talk About the COVID-19 Vaccine](#)
- [COVID-19 Vaccination for Young People FAQs](#)
- Vaccination Options for Children and Families
 - [English](#)
 - [Spanish](#)
- [ICAAP Vaccination Letter](#)

Requesting Vaccination Status Information

According to the federal Equal Employment Opportunity Commission,¹⁹ federal laws do not prevent an employer, including schools, from requiring all employees physically entering the workplace to be vaccinated for COVID-19, so long as employers comply with the reasonable accommodation provisions of the Americans with Disabilities Act (ADA) and Title VII of the Civil Rights Act of 1964 and other equal employment opportunity considerations.

Everyone 12 years of age and older is now eligible to get a free COVID-19 vaccination. Please see the [CDC website for the most updated eligibility guidance](#).

Schools can choose how and whether they will identify individuals who have been vaccinated and should communicate their strategies and any changes in plans to teachers, to staff, and to families, and directly to older students.

Schools that plan to request voluntary submission of documentation of COVID-19 vaccination status should use the same standard protocols that are used to collect and secure other immunization or health status information from students. For example, Illinois state law²⁰ and administrative code²¹ requires children enrolled in child care or school to be immunized against certain preventable communicable diseases, including highly contagious viral illnesses such as measles, mumps, and varicella (chickenpox). Prior to entering any public, private, independent, or parochial school, every child in Illinois must provide the school with documentation from their health care provider that verifies their immunizations, with certain exceptions. Schools that request proof of vaccination for COVID-19 may use this existing infrastructure to document students' vaccination status.

The protocol to collect, to secure, to use, and to further disclose this information should comply with relevant statutory and regulatory requirements, including Family Educational Rights and Privacy Act (FERPA) statutory and regulatory requirements.

Local school authorities are permitted to access the statewide immunization database to review student immunization records. Only employees who have direct responsibility for ensuring student compliance with [77 Ill. Adm. Code 665.210](#) can apply for and receive access to the [Illinois Comprehensive Automated Immunization Registry Exchange](#) (I-CARE), the statewide

¹⁹ U.S. Equal Employment Opportunity Commission. (2021, May 28). What you should know about COVID-19 and the ADA, the Rehabilitation Act, and other EEO laws. Retrieved from <https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws>

²⁰ Section 27-8.1 of the School Code [105 ILCS 5] at <https://www.ilga.gov/legislation/ilcs/documents/010500050K27-8.1.htm> Ill. Adm. Code.

²¹ 77 Ill. Adm. Code Part 665 Child and Student Health Examination and Immunization Code at <https://www.ilga.gov/commission/jcar/admincode/077/07700665sections.html>

system. No access will be granted to other personnel, such as superintendents or human resource managers. All individuals with I-CARE access are subject to all [requirements and penalties](#) authorized by the [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#). School employees may apply for access to I-CARE by following the instructions in the [I-CARE access enrollment packet](#). Contact I-CARE program staff via email at dph.icare@illinois.gov for more information.

Parents/guardians may choose to provide their child's COVID-19 vaccination status, and school or district employees may choose to provide their vaccination status, to their school or district through official documentation of vaccination status, i.e., COVID-19 Vaccination Record or official documentation from their health care provider. Adults can authorize release of such proof for themselves or their children by completing a [request for immunization records \(for Chicago residents\)](#) from I-CARE.

As families and communities continue to increase vaccine uptake, schools and districts must ensure all students, no matter their vaccination status, continue to have access to full-time in-person instruction.

2. Require all teachers, staff, students, and visitors to P-12 schools to wear a mask while indoors, regardless of vaccination status.

This guidance is based on updated recommendations in CDC guidance for COVID-19 prevention in K-12 schools and an updated Executive Order for the State of Illinois. [Executive Order 2021-18](#) requires that all teachers, staff, students, and visitors to P-12 schools who are two years of age or older and medically able to tolerate a mask, regardless of vaccination status, to wear a mask while indoors.

All persons, regardless of vaccination status, must wear a face mask at all times when in transit to and from school via group conveyance (e.g., school buses), unless a specific exemption applies. This is in accordance with the [CDC Order](#), in effect as of February 1, 2021, which requires “the wearing of masks by people on public transportation conveyances or on the premises of transportation hubs to prevent the spread of the virus that causes COVID-19.”

Exceptions to universal consistent use of face masks include the following limited situations:

- When eating.
- If using a face shield when other methods of protection are not available or appropriate. (View guidance on [appropriate use of face shields](#).)
- For children while they are napping with close monitoring to ensure no child leaves their designated napping area without putting their face mask back on.
- For staff when alone in classrooms or offices with the door closed.
- For individuals who are younger than 2 years of age.
- For individuals who have trouble breathing; or those who are unconscious, incapacitated, or otherwise unable to remove the face mask without assistance.

- For persons with a disability who cannot wear a mask, or cannot safely wear a mask, because of the disability as defined by the [Americans with Disabilities Act](#) (ADA, 42 U.S.C. 12101 *et seq.*), including:
 - A person with a disability who, for reasons related to the disability, would be physically unable to remove a mask without assistance if breathing becomes obstructed. Examples might include a person with impaired motor skills, quadriplegia, or limb restrictions.
 - A person with an intellectual, developmental, cognitive, or psychiatric disability that affects the person's ability to understand the need to remove a mask if breathing becomes obstructed.
- For individuals who have a condition or medical contraindication (e.g., difficulty breathing) that prevents them from wearing a face mask.
- For fully vaccinated staff when meeting with other fully vaccinated staff outside of settings where unvaccinated persons are present.
- For staff and students when they are outdoors. However, particularly in areas of [substantial to high transmission](#), staff and students who are not fully vaccinated should wear a mask in crowded outdoor settings or during activities that involve sustained close contact with other people who are not fully vaccinated.

Staff and students who remove their face mask in these limited situations should be monitored and should maintain physical distancing to the greatest extent possible given the space in their facilities, with at least 3 feet recommended, but not required, between students and at least 6 feet recommended, but not required, between adults or between students and adults.

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

Most students, including those with disabilities, can tolerate and safely wear a face mask. Students with an Individualized Education Program or 504 Plan who are unable to wear a face mask or face shield due to a medical contraindication may not be denied access to an in-person education if the school is offering in-person education to other students. Staff working with students who are unable to wear a face mask or shield due to a medical contraindication should wear approved and appropriate personal protective equipment (PPE) based on job-specific duties and risks and maintain physical distancing as much as possible. Other students should also remain distant from students who are unable to wear a face mask or face shield due to a medical contraindication. Schools should consult with their local health department regarding appropriate PPE for these situations.

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

Face Masks

According to the [CDC scientific brief on transmission of SARS-CoV-2](#), the virus that causes COVID-19, the principal mode by which people are infected is through exposure to respiratory fluids, most commonly by inhalation of smaller droplets or direct splashes or sprays of larger droplets that are deposited in someone’s mouth, nose, or eyes. Masks act as source control to block the release of exhaled respiratory droplets and filter some droplets to reduce exposure by inhalation. There is significant evidence that face masks provide protection and decrease the spread of COVID-19, including in schools.²² According to the [CDC scientific brief on the use of cloth masks to control the spread of SARS-CoV-2](#), at least 10 studies have confirmed the benefit of universal masking, documenting that new COVID-19 infections fell significantly following directives for universal masking.

The [face mask should have two or more](#) layers to stop the spread of COVID-19 and should be worn over the nose and mouth, be secured under the chin, and should fit snugly against the sides of the face without gaps. Reusable face masks should be machine washed or washed by hand and allowed to dry completely after each use. Additionally, pay special attention to putting on and removing face masks for purposes such as eating. After use, the front of the face mask is considered contaminated and should not be touched during removal or replacement. Hand hygiene should be performed immediately after removing and after replacing the face mask. See [CDC guidance on how to wear and take off a mask](#) for additional instruction. Districts and schools may wish to maintain a supply of disposable face masks in the event that a staff member, student, or visitor does not have one for use. School leaders, local leaders, and others respected in the community should set an example by correctly and consistently wearing masks. For additional information, see [CDC guidance for wearing masks](#).

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

²² Gettings, J., Czarnik, M., Morris, E., Haller, E., Thompson-Paul, A. M., Rasberry, C., Lanzieri, T. M., Smith-Grant, J., Aholou, T. M., Thomas, E., Drenzek, C., & MacKellar, D. (2021, May 28). Mask use and ventilation improvements to reduce COVID-19 incidence in elementary schools – Georgia, November 16–December 11, 2020. *Morbidity and Mortality Weekly Report*, 70(21), 779–784. <http://dx.doi.org/10.15585/mmwr.mm7021e1>

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

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

Other Recommendations for use of PPE

Ensure that appropriate PPE is made available to and used by staff, as needed, based on exposure risk. Provide training to staff prior to the start of student attendance on the proper use of PPE, including the sequence for putting on and removing PPE. In addition, training should also include directions on the proper disposal of PPE since inappropriate application or removal of PPE can increase the transmission. Employers are required to comply with Occupational Safety and Health Administration (OSHA) [standards](#) on bloodborne pathogens, including the [proper disposal of PPE and regulated waste](#).

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

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

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

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

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

3. Facilitate physical distancing. Schools should configure their spaces to provide space for physical distancing to the extent possible in their facilities.

Physical distancing provides protection, minimizes risk of exposure, and limits the number of close contacts. CDC recommends schools maintain at least 3 feet of physical distance between students within classrooms to reduce transmission risk. No school should exclude students from in-person learning to keep a minimum distance requirement.

Schools should provide for the maximum space possible between students and between students and staff, within the school facilities' physical capabilities. Districts and schools may wish to post visual reminders throughout school buildings and lay down tape or other indicators of safe distances in areas where students may remove masks, congregate, or line up (e.g., arrival and departure, lunchroom lines, hallways, recess lines, libraries, cafeterias). When face masks are removed in limited situations (e.g., lunchrooms), it is especially important that school staff facilitate physical distancing to the greatest extent possible within the school facilities' physical capabilities. Districts and schools may consider increasing physical distancing measures when community transmission levels are substantial or high.

Physical distance should be measured as the distance between persons (i.e., "mouth to mouth") rather than between furniture (e.g., desk to desk). A distance of at least 3 feet is recommended between unvaccinated students, but not required. A distance of at least 6 feet is recommended between unvaccinated adults or between unvaccinated adults and students, but not required. When unvaccinated persons cannot maintain recommended physical distancing, strict adherence to masking is especially important.

There is no recommended capacity limit for school transportation. Schools should facilitate physical distancing on school transportation vehicles to the extent possible given the space on such vehicles.

Mealtimes represent one of the highest-risk settings within the school. Masks are removed and the act of eating and talking, usually with increased projection, can increase transmission risk. Physical distancing of 3 feet is recommended for students while eating or drinking. Given the risk of transmission among unvaccinated persons while unmasked, a distance of at least 6 feet is recommended for all unvaccinated individuals while eating and drinking, but is not required.

Districts and schools may wish to consider "staggering" schedules for arrivals/dismissals, hall passing periods, mealtimes, bathroom breaks, etc. to ensure the safety of unvaccinated students

and staff. Staff and students should abstain from physical contact, including, but not limited to, handshakes, high fives, and hugs.

[Cohorts](#) (or “pods”) are activities or classes that are grouped together to the extent possible during the school day in order to minimize exposure to other individuals in the school environment. When implementing cohorts, schools should keep them as static as possible by having the same group of students stay with the same teachers or staff (all day for young children, and as much as possible for older children). If additional space is needed to support cohorting, consider all available safe spaces in school and community facilities. Limit mixing between cohorts. Students and staff in the same cohort who are not fully vaccinated should continue to wear masks at all times, except as otherwise noted in this guidance.

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

School athletics must comply with the latest [Sports Safety Guidance](#).

Evidence suggests that staff-to-staff transmission is more common than transmission from

students to staff, staff to student, or student to student.^{23 24 25 26 27} Districts and schools should address staff-to-staff transmission and limit these exposures, primarily focused on unvaccinated staff. Nonessential exposures among unvaccinated staff should be minimized, including both physical and professional meetings. For example, staff break areas should be arranged to facilitate physical distancing and break times should be staggered to minimize exposure while eating with face mask off near others. Measures to prevent transmission among staff, including promotion of COVID-19 precautions outside of the school and vaccination, will likely reduce in-school transmission.²⁸

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

Contact Tracing

Districts and schools, as well as students and families, must work with local health departments to facilitate [contact tracing](#) of infectious students, teachers, and staff, and consistent implementation regarding isolation of cases and quarantine of close contacts. Contact tracing is

²³ Ismail, S. A., Saliba, V., Lopez-Bernal, J., Ramsay, M. E., & Ladhani, S. N. (2021, March 1). SARS-CoV-2 infection and transmission in educational settings: A prospective, cross-sectional analysis of infection clusters and outbreaks in England. *The Lancet Infect Diseases*, 21(3), 344-353. [https://doi.org/10.1016/S1473-3099\(20\)30882-3](https://doi.org/10.1016/S1473-3099(20)30882-3)

²⁴ Gandini, S., Rainisio, M., Iannuzzo, M. L., Bellerba, F., Cecconi, F., & Scorrano, L. (2020). No evidence of association between schools and SARS-CoV-2 second wave in Italy [pre-print]. *mexRxiv*. <https://doi.org/10.1101/2020.12.16.20248134>

²⁵ Stein-Zamir, C., Abramson, N., Shoob, H., Libal, E., Bitan, M., Cardash, T., Cayam, R., & Miskin, I. (2020). A large COVID-19 outbreak in a high school 10 days after schools' reopening, Israel, May 2020. *Eurosurveillance*, 25(29), 2001352. <https://doi.org/10.2807/1560-7917.ES.2020.25.29.2001352>

²⁶ Yung, C. F., Kam, K. Q., Nadua, K. D., Chong, C. Y., Tan, N. W. H., Li, J., Lee, K. P., Chn, Y. H., Thoon, K. C., & Ng, K. C. (2020). Novel coronavirus 2019 transmission risk in educational settings. *Clinical Infectious Diseases*, 72(6), 1055-1058. <https://doi.org/10.1093/cid/ciaa794>

²⁷ Ehrhardt, J., Ekinci, A., Krehl, H., Meincke, M., Fieni, I., Klein, J., Geisel, B., Wagner-Wiening, C., Eichner, M., & Brockmann, S. O. (2020). Transmission of SARS-CoV-2 in children aged 0 to 19 years in childcare facilities and schools after their reopening in May 2020, Baden-Württemberg, Germany. *Eurosurveillance*, 25(36), 2001587. <https://doi.org/10.2807/1560-7917.ES.2020.25.36.2001587>

²⁸ Gold, J. A. W., Gettings, J. R., Kimball, A., Franklin, R., Rivera, G., Morris, E., Scott, C., Marcet, P. L., Hast, M., Swanson, M., McCloud, J., Mehari, L., Thomas, E. S., Kirking, H. L., Tate, J. E., Memark, J., Drenzek, C., Vallabhaneni, S., & Georgia K-12 School COVID-19 Investigation Team. (2021, February 26). Clusters of SARS-CoV-2 infection among elementary school educators and students in one school district – Georgia, December 2020-January 2021. *Morbidity and Mortality Weekly Report*, 70(8), 289-292. <http://dx.doi.org/10.15585/mmwr.mm7008e4>

used by health departments to prevent the spread of infectious diseases. In general, contact tracing involves identifying people who have a confirmed or probable case of COVID-19 (cases) and individuals with whom they came in contact (close contacts) and working with such individuals to interrupt disease spread. This includes asking people with COVID-19 to [isolate](#) and their contacts to [quarantine](#) at home voluntarily.

Students and staff who are fully vaccinated with no COVID-19-like symptoms do not need to quarantine or be restricted from school or extracurricular activities. CDC recommends that fully vaccinated individuals test three to five days after a close contact exposure to someone with suspected or confirmed COVID-19.

Schools can prepare and provide information and records to aid in the identification of potential unvaccinated contacts, exposure sites, and mitigation recommendations that are consistent with applicable laws, including those related to privacy and confidentiality. Local health department collaboration with P-12 school administration to obtain contact information of other unvaccinated individuals in shared rooms, class schedules, shared meals, or extracurricular activities will expedite contact tracing and control the spread of COVID-19 infection.

Schools should institute a tracking process to maintain ongoing monitoring of individuals excluded from school because they have COVID-19-like symptoms, have been diagnosed with COVID-19, or have been exposed to someone with COVID-19 and are in quarantine. Tracking ensures CDC and local health department criteria for discontinuing home isolation or quarantine are met before a student or staff member returns to school. Tracking methods include checking in with the school health personnel upon return to school to verify resolution of symptoms and that any other criteria for discontinuation of quarantine have been met. Tracking should take place prior to a return to the classroom. Schools should communicate this process to all members of the school community prior to the resumption of in-person learning. This communication should be translated into the languages appropriate for the communities served.

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

Individuals who exhibit symptoms should be referred to a medical provider for evaluation, treatment, and information about when they can return to school, according to the [IDPH Decision Tree for Symptomatic Individuals in Pre-K, K-12 Schools and Day Care Programs \(Spanish translation\)](#). Confirmed cases of COVID-19 should be reported to the local health department by the school health personnel or designee as required by the [Illinois Infectious Disease Reporting](#) requirements issued by IDPH.

Districts and schools should inform the school community of outbreaks per local and IDPH guidelines while protecting the confidentiality of students and staff. In addition to the previously referenced Decision Tree, schools should also refer to [IDPH Public Health Interim Guidance for Pre-K-12 Schools and Day Care Programs for Addressing COVID-19](#) and [IDPH Interim Post-Vaccination Considerations for Schools](#) for complete details on procedures for handling children/staff with symptoms, those who test positive, and those who are identified as close contacts and must be quarantined or tested.

Definition of a Close Contact

For all individuals where exposure occurred outside of the classroom setting and for adults in the indoor P-12 classroom setting, CDC defines a [close contact](#) as an individual not fully vaccinated against COVID-19 who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period. For students in the classroom setting, contacts who were within 3 to 6 feet of an infected student do not require quarantine as long as both the case and the contact were consistently masked. If they were not consistently masked, then close contacts are classroom students who were within 6 feet of the infected student for a cumulative total of 15 minutes or more over a 24-hour period.

In general, individuals who are solely exposed to a confirmed case while outdoors should not be considered close contacts.

The longer a person is exposed to an infected person, the higher the risk of exposure or transmission. The infectious period of close contact begins two calendar days before the onset of symptoms (for a symptomatic person) or two calendar days before the positive sample was obtained (for an asymptomatic person). If the case was symptomatic (e.g., coughing, sneezing), persons with briefer periods of exposure may also be considered contacts, as determined by local health departments. Persons who have had lab-confirmed COVID-19 within the past 90 days or those fully vaccinated, according to CDC guidelines, are not required to quarantine if identified as a close contact to a confirmed case.

Local health departments are the final authority on identifying close contacts.

Quarantine Procedures

Local health departments will make the final determination on who is to be quarantined and for how long. They also may determine that a close contact is not a candidate for modified quarantine due to a high-risk exposure (e.g., sustained close contact without masking).

The CDC describes three options for [quarantine](#):

- **Option 1:** Quarantine at home for 14 calendar days. Date of last exposure is considered day 0.
- **Option 2:** Quarantine for 10 calendar days after the close contact's last exposure to the COVID-19 case. Date of last exposure is considered day 0.
 - The individual may end quarantine after day 10 if no symptoms of COVID-19 developed during daily monitoring.

- SARS-CoV-2 PCR testing is recommended and may be required by the local health department.
- The individual can maintain physical distancing and masking at all times when returning to school; for classrooms where masking is strictly adhered to as required, physical distance of 3 to 6 feet is acceptable for return.
- **Option 3:** Quarantine period is for seven calendar days after the last exposure if:
 - No symptoms developed during daily monitoring AND the individual has a negative SARS-CoV-2 diagnostic test (PCR) that was collected within 48 hours of exposure day 7 (starting on day 6 or after).
 - The individual is responsible for obtaining a copy of the negative results for documentation purposes.
 - The individual can maintain physical distancing and masking at all times when returning to school; for classrooms where masking is strictly adhered to as required, physical distance of 3 to 6 feet is acceptable for return.

Regardless of when an individual ends quarantine, daily symptom monitoring should continue through calendar day 14 after the exposure. If any symptoms develop during or after ending quarantine, the individual should immediately self-isolate and contact their local health department or healthcare provider to report their symptoms. The health department can provide guidance on how to safely quarantine and isolate within the household.

Test to Stay Protocol

IDPH now allows a modified quarantine approach for close contacts through a Test to Stay protocol, as has been documented by the CDC.²⁹ Following any indoor exposures, with the exception of household exposures, if schools test close contacts on days one, three, five, and seven from date of exposure by a PCR or rapid Emergency Use Authorization (EUA)-approved test, close contacts are permitted to remain in the classroom as long as the results are negative. If the close contact is identified five days or more from the date of exposure, adjust testing accordingly, ideally on days five and seven after the last exposure. When testing in the outlined cadence is not possible due to weekends and holidays, students and staff who are not fully vaccinated should be tested at the earliest possible opportunity. Test to Stay is only applicable when both the COVID-19-confirmed case and close contact were engaged in consistent and correct use of well-fitting masks, regardless of vaccination status (universal masking), as required by [Executive Order 2021-18](#).

²⁹ Lanier, W. A., Babitz, K. D., Collingwood, A., Graul, M. F., Dickson, S., Cunningham, L., Dunn, A. C., MacKellar, D., & Hersh, A. L. (2021, May 28). COVID-19 testing to sustain in-person instruction and extracurricular activities in high schools – Utah, November 2020-March 2021. *Morbidity and Mortality Weekly Report*, 70(21), 785-791. <http://dx.doi.org/10.15585/mmwr.mm7021e2>

While engaged in Test to Stay after an exposure, students and staff who are not fully vaccinated may participate in extracurricular activities. At the conclusion of the Test to Stay modified quarantine period, the school should notify the local health department that the individual has successfully completed testing and remained negative. If at any time the student or staff person who is not fully vaccinated tests positive or becomes symptomatic, they should be immediately isolated and sent home, and the local health department notified.

Local health departments will make the final determination on who is to be quarantined and for how long and may determine that a close contact is not a candidate for modified quarantine due to a high-risk exposure (e.g., sustained close contact without masking). Local health departments have the authority to assess high-risk exposures and order a traditional quarantine without the option for Test to Stay. Test to Stay is only applicable when both the COVID-19-confirmed case and close contact were engaged in consistent and correct use of well-fitting masks, regardless of vaccination status (i.e., universal masking), as required.

See [IDPH's Interim Guidance on Testing for COVID-19 in Community Settings and Schools](#) for more details on testing in schools.

5. Implement or provide provisions for SARS-CoV-2 testing for diagnostic testing for suspected cases, close contacts, and during outbreaks, as well as screening testing for unvaccinated staff and students according to CDC's testing recommendations.

Viral testing strategies are an important part of a comprehensive mitigation approach. Testing is most helpful in identifying new cases to prevent outbreaks, to reduce risk of further transmission, and to protect students and staff from COVID-19. The [Decision Tree for Symptomatic Individuals](#) should be used to guide testing approaches of symptomatic staff or students and need for use of a polymerase chain reaction (PCR) test for confirmation. For additional guidance on testing, including what types of tests are appropriate for use on asymptomatic individuals, refer to the IDPH [Interim Guidance on Testing for COVID-19 in Community Settings and Schools](#). Schools can find more information in IDPH's answers to [FAQs about COVID-19 testing in schools](#).

The hierarchy of testing for COVID-19 in schools is first for persons with symptoms of COVID-19, regardless of vaccination status, followed by close contacts to a confirmed case, and all staff and students with possible exposure in the context of an outbreak. Testing may also be used for screening purposes. This involves serial testing of asymptomatic persons. In areas where community spread of COVID-19 is low (i.e., fewer than 10 new cases per 100,000 population in the past seven days), IDPH recommends schools adopt weekly screening testing of unvaccinated students and staff that are participating in extracurricular activities. Persons who are fully vaccinated or who have recovered from COVID-19 in the past three months should be excluded from screening testing. Contact tracing should immediately begin if anyone tests positive for COVID-19.

The state of Illinois has made testing available free of charge to all schools in Illinois through SHIELD Illinois. Those interested in establishing a P-12 testing program using the

SHIELD Illinois saliva test should contact Beth Heller, senior director of External Affairs for SHIELD Illinois, at bheller@uillinois.edu. Note: SHIELD Illinois is also able to offer BinaxNOW rapid antigen testing along with its weekly saliva testing program. Those interested in implementing a P-12 testing program using the BinaxNOW rapid antigen test should email dph.antigentesting@illinois.gov. (See the [IDPH Interim Guidance on Testing for COVID-19 in Community Settings and Schools](#) for complete information on testing.)

Outbreak testing is strongly recommended for schools in outbreak status (two or more cases linked epidemiologically that do not share the same household and are not listed as close contacts of each other outside the outbreak setting). Implementation of outbreak testing should begin as soon as possible from the date the outbreak is declared and at least within three days. IDPH recommends schools acquire parental consent for student testing at the beginning of the school year to accommodate outbreak testing should the need arise. Schools should conduct twice weekly testing of unvaccinated staff and students targeted to the impacted classroom(s), grade(s), extracurricular participants, or entire student body, depending on the circumstances, unless the local health department recommends otherwise. Testing should continue until the school has gone two incubation periods, or 28 days, without identifying any new cases. If testing is not already in place for screening, schools should make plans to deploy outbreak testing when needed. A listing of free testing sites is available at <http://dph.illinois.gov/testing>.

Additionally, SHIELD Illinois can be quickly deployed to a school setting by emailing Beth Heller, Senior Director of External Affairs for SHIELD, at bheller@uillinois.edu. For schools partnering with SHIELD Illinois for weekly screening, outbreak testing is included in the testing program. For districts without weekly screening, outbreak only testing through SHIELD Illinois is available by contacting Beth Heller, bheller@uillinois.edu. However, prioritization of outbreak testing will be given to districts with weekly screening programs. Schools can also utilize BinaxNOW rapid antigen testing for their outbreak response by emailing dph.antigentesting@illinois.gov.

Results from COVID-19 point-of-care (POC) antigen tests (e.g., BinaxNOW) should be interpreted based on the test sensitivity and specificity, whether the individual being tested has symptoms, and level of transmission in the community and the facility. A confirmatory [nucleic acid amplification test](#) (NAAT) may be needed in certain situations. Because laboratory-based NAATs are considered the most sensitive tests for detecting SARS-CoV-2, the virus that causes COVID-19, they can also be used to confirm the results of lower sensitivity tests, such as POC NAATs or rapid antigen tests, such as BinaxNOW. While the SHIELD Illinois saliva test is a highly reliable laboratory-based NAAT and does not require an additional confirmatory test when used as a primary diagnostic test, CDC recommends collecting and testing an upper respiratory specimen, such as nasopharyngeal, nasal mid-turbinate, or anterior nasal, when using NAATs for confirmatory testing. An upper respiratory test, such as the BinaxNOW rapid antigen test, should be confirmed by a laboratory-based NAAT performed on an upper-respiratory specimen.

See [Test to Stay Protocol](#) for more information.

6. Improve ventilation to reduce the concentration of potentially virus-containing droplets in schools' indoor air environments.

Schools should work to improve [ventilation](#) to the extent possible, including some or all of the

following activities:

- Increase outdoor air ventilation, using caution in highly polluted areas.
 - When weather conditions allow, increase fresh outdoor air by opening windows and doors. Do not open windows and doors if doing so poses a safety or health risk (e.g., risk of falling, triggering asthma symptoms) to children using the facility.
 - Use child-safe fans to increase the effectiveness of open windows. Position fans securely and carefully in or near windows so as not to induce potentially contaminated airflow directly from one person over another. Strategically place fans to help draw fresh air into the classroom from open windows or to blow air from the classroom out open windows.
 - Decrease occupancy in areas where outdoor ventilation cannot be increased.
- Ensure ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space.
- Increase total airflow supply to occupied spaces, when possible.
- Disable demand-controlled ventilation controls that reduce air supply based on occupancy or temperature during occupied hours.
- Further open outdoor air dampers to reduce or eliminate heating, ventilation, and air conditioning (HVAC) air recirculation. In mild weather, this will not affect thermal comfort or humidity; however, this will be difficult to do in cold, hot, or humid weather.
- Improve central air filtration:
 - [Increase air filtration](#) to as high as possible without significantly diminishing design airflow.
 - Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass
 - Check filters to ensure they are within service life and appropriately installed.
- Consider running the HVAC system at maximum outside airflow for two hours before and after the school is occupied.
- Ensure restroom exhaust fans are functional and operating at full capacity when the school is occupied.
- Inspect and maintain local exhaust ventilation in areas such as restrooms, kitchens, cooking areas, etc.
- Use portable high-efficiency particulate air fan/filtration systems to help enhance air cleaning (especially in higher risk areas, such as the health office).
- Generate clean-to-less-clean air movement by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers (especially in higher risk areas, such as the health office).
- Consider using ultraviolet germicidal irradiation as a supplement to help inactivate the virus that causes COVID-19, especially if options for increasing room ventilation are limited.
- Consider that ventilation is also important on school buses.

7. Promote and adhere to handwashing and respiratory etiquette.

Districts and schools should encourage frequent and proper handwashing. Ensure availability of supplies, such as soap, paper towels, and hand sanitizer for all grade levels and in all common

areas of the building. Cloth towels should not be used. Handwashing with soap and water is always the first recommended line of defense, but where this is not feasible or readily accessible, the use of hand sanitizer with at least 60% alcohol may be used. Districts and schools should be cognizant of any students or staff members with sensitivities or allergies to hand sanitizer or soap and ensure easy access to appropriate alternatives.

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

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

- Alcohol-based hand sanitizers should be used under adult supervision with proper child safety precautions and stored out of reach of young children to reduce unintended, adverse consequences. It will be necessary to ensure that students do not ingest hand sanitizer or use it to injure another person.
- Alcohol-based hand sanitizers must be properly stored – which includes away from high temperatures or flames – in accordance with National Fire Protection Agency recommendations.
- Hand sanitizers are not effective when hands are visibly dirty. Use soap and water to clean visibly soiled hands.
- Alcohol-based hand sanitizers do not remove allergenic proteins from the hands.
- Staff preparing food in the cafeteria/kitchen should ALWAYS wash their hands with soap and water. The IDPH Food Service Sanitation Code³⁰ does not allow persons who work in school cafeteria programs to use hand sanitizers as a substitute for handwashing.
- The FDA controls sanitizers as over-the-counter drugs because they are intended for topical antimicrobial use to prevent disease in humans.

Educate staff and students on healthy hygiene and handwashing to prevent the spread of infection. Monitor to ensure adherence among staff and students. Schools may wish to post handwashing posters in the bathrooms, hallways, classrooms, and other areas, as appropriate. See

³⁰ Illinois Department of Public Health, Food Service Sanitation Code, 77 Illinois Administrative Code Part 750: <https://www.ilga.gov/commission/jcar/admincode/077/07700750sections.html>

CDC's [Handwashing: Clean Hands Save Lives](#) for free resources. Ensure availability of resources for teachers, school health personnel, and other staff members so they can appropriately train students or review handwashing procedures. Various [classroom lesson, activities, and resources](#) are available.

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

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

8. Encourage individuals who are sick to stay home and get tested for COVID-19.

Schools should post signage and otherwise communicate to students and staff that they are discouraged from entering buildings or boarding school transportation if ill.

Both the [CDC operational guidance for K-12 schools](#) and this joint guidance no longer recommend fever and symptom screening by school staff upon arrival at school. Instead, self-screening for [COVID-19-like symptoms](#), as well as any other symptoms of [common respiratory viruses and ailments](#), prior to arriving on school grounds or boarding school transportation continues to be recommended.

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

9. Clean and disinfect surfaces in schools to maintain healthy environments.

Districts and schools should develop sanitation procedures per recommendations of the CDC, IDPH, and local health departments. In April 2021, the CDC issued a scientific brief on SARS-CoV-2 and surface transmission for indoor environments that concluded:

Routine cleaning performed effectively with soap or detergent, at least once per day, can substantially reduce virus levels on surfaces. When focused on high-touch surfaces, cleaning with soap or detergent should be enough to further reduce the relatively low transmission risk from fomites in situations when there has not been a suspected or confirmed case of COVID-19 indoors. In situations when there has been a suspected or

*confirmed case of COVID-19 indoors within the last 24 hours, the presence of infectious virus on surfaces is more likely and therefore high-touch surfaces should be disinfected.*³¹

Clean with products containing soap or detergent to reduce germs on surfaces and objects that will remove contaminants and may weaken or damage some of the virus particles to decrease the risk of infection from surfaces. Clean high-touch surfaces and shared objects at least once a day. For more information on cleaning and disinfecting schools, see [Cleaning and Disinfecting Your Facility](#).

Clean more frequently and disinfect surfaces and objects if certain conditions apply:

- High transmission of COVID-19 in your community
- Low number of people wearing masks or improper mask usage
- Infrequent hand hygiene
- The space is occupied by people at [increased risk for severe illness from COVID-19](#)

If someone in your school is sick or someone who has COVID-19 has been in your school in the last 24 hours, [clean and disinfect](#) the facility.

Ensure that [U.S. Environmental Protection Agency \(EPA\)-approved disinfectants](#) for use against COVID-19 are available to staff responsible for cleaning. If not available, consult your local health department for guidance on alternative disinfectants.

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

Before students and staff return to a school or childcare building that has been closed for an extended time, look for ways to reduce potential hazards. [Flush plumbing](#) (including all sink faucets, water fountains, water bottle fillers, hoses, and showers) to replace all water inside building pipes with fresh water. This can help protect occupants from possible exposure to [lead](#), [copper](#), and [Legionella](#) bacteria. You can also follow the EPA 3Ts – [Training, Testing, and Taking Action – for reducing lead in drinking water at schools and](#) childcare centers.

³¹ Santarpia, J. L., Rivera, D. N., Herrera, V. L., Morwitzer, M. J., Creager, H. M., Santarpia, G. W., Crown, K. K., Brett-Major, D. M., Schnaubelt, E. R., Broadhurst, M. J., & Lawler, J. V. (2020). Aerosol and surface contamination of SARS-CoV-2 observed in quarantine and isolation care. *Scientific Reports*, 10(1), 1-8.
<https://doi.org/10.1038/s41598-020-69286-3>



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