Return to School Roadmap
The East Cleveland City Schools PreK-12
(As of 4-15-21)

Contents

Message from the CEO/Superintendent

The following Roadmap, dated April 15, 2021, has been established for the continued operation of the East Cleveland City School District.

As we continue to navigate the process of reopening schools, it is essential that we be persistent in our understanding of the details and the appropriate execution of mitigating responses. Any plan to put structures in place for the safe reopening of our school district should be viewed as a living design, guided by the body of constantly evolving information and expert advice on how best to keep our children, our workers and our communities' safe from the continued spread of COVID-19.

Schools are an important part of the infrastructure of communities and play a critical role in supporting the whole child, not just their academic achievement. The fabric of support woven in schools is often essential to the wellbeing of our children, families and the community at large. The East Cleveland City Schools provide safe, supportive learning environments for students, employ teachers and other staff, and enable parents, guardians, and caregivers to work. We also provide critical services that help to mitigate health disparities, such as school meal programs, and social, physical, behavioral, and mental health services. The disruption of the delivery of these critical services can be devastating to any and all communities.

We as a District had an outstanding show of participation in the first round (Phase 1 B) of Ohio's statewide COVID-19 phased distribution approach. During this initial phase, vaccine administration was focused on reaching critical groups, which included adults who work in schools. However, In lieu of a successful period of vaccine distribution, we must continue to take specific steps to map out our new normal, and continue to adjust, rework and implement mitigation strategies based on the evolution of the impact of COVID-19 on the world, the country and our specific community.

In addition to the updating of this document, our **Return to School Roadmap**, on February 9, 2021, Governor Mike DeWine asked schools and districts to work with their communities and educational stakeholders to help students continue to advance academically and to make up for any learning that may have been lost or delayed due to the coronavirus pandemic and related disruptions. With this task, it has been requested of us that schools and districts design plans that address learning recovery and extended learning opportunities to meet the needs of students. **The East Cleveland City Schools PreK-12 Learning Recovery & Extended Learning Plan was submitted for review on April 1, 2021.**

While the science pertaining to this pandemic continues to evolve, it is even more important, at this juncture, to remain vigilant and nimble in our reactions to new developments. We must continue to not be rigid in thought. The intent of this resource is to be fluid and adaptable to the evolving climate based on the impact of COVID-19. **WE NEED AND WANT OUR CHILDREN AND STAFF TO BE IN SCHOOL**, but most of all, we want to secure the health, well-being and future for all of our children and every member of the community at large. No effort is small. Each of us must adhere to and maintain safe and healthy practices that will ensure the continuity of operations of our entire school District.

Sincerely,

Dr. Henry Pettiegrew II,
Chief Executive Officer & Superintendent

Date 4/20/2021

Guiding Principles

OUR VISION

The East Cleveland City School District will be the model urban school for student achievement focused on the whole child.

OUR MISSION

We will provide the children of East Cleveland with the academic and social-emotional preparation to succeed in the college and/or career pathway of their choice.

The Guidelines

I. Vigilantly assessing symptoms - Students, caregivers and staff are asked to monitor their health before departing for school. Those with temperatures over 100 degrees are asked to stay home. Students and staff who develop symptoms at school will be sent home. Schools will need to work with their local health departments to trace cases and conduct testing.
II. Hand washing - Schools must provide time for students and staff to regularly wash hands. Hand washing and sanitation stations are to be set up within each building.
III. Sanitation and deep cleaning schools - Schools will be required to regularly disinfect the school and high touch areas to mitigate the spread of the virus.
IV. Practicing social distancing - Schools should strive to maintain 6-feet of distance between students and staff in classrooms, lunchrooms, school busses, and other school settings when possible to limit exposure to COVID-19.
V. Face coverings – There is an established District face-covering policy. All persons will be required to wear a mask or face covering in our District to ensure the health and well-being of everyone.

COVID-19 Defined

COVID-19 is mostly spread by respiratory droplets released when people talk, cough, or sneeze. It is thought that the virus may spread to hands from a contaminated surface and then to the nose or mouth, causing infection. Therefore, personal prevention practices (such as handwashing, staying home when sick) and environmental cleaning and disinfection are important principles that help lower the risk of COVID-19 exposure and spread during school sessions and activities.

EDUCATIONAL LEARNING

- Provide in-person instruction for all attending students as much as possible with high-risk students & families receiving priority placement.
- Provide a fully online (virtual) option for K-12 students.
- Be prepared to return to remote learning at any time due to COVID-19.

HEALTH SAFETY

We will continue to follow guidance from Ohio Department of Health, Ohio Department of Education, Center for Disease Control and Prevention, Ohio High School Athletic Association and the Cuyahoga County Board of Health. Health and safety continues to be the Districts priority as we plan for a responsible return to school.

- We will communicate, educate, and reinforce appropriate hygiene and social distancing practices in ways that are developmentally appropriate for students, teachers, and staff.
- All students must adhere and are required to follow the COVID safety procedures outlined in the district plan to remain in the face-to-face environment
- A mask is required for all learners unless the IEP team determines that reasonable modifications to the district's policies, practices, or procedures – including any addressing the use of face coverings- when those modifications can be made consistent with health, safety, and well-being of all students and staff, and are necessary to avoid discrimination based on disability

SOCIAL - EMOTIONAL

Support social emotional learning and interaction to the fullest extent while practicing social distancing.

Public Health Alert System

The East Cleveland City School District uses Governor DeWine's Public Health Advisory System in determining our return-to-learning plans, and to update our plans throughout the 2020-21 school year.

The decision making process for our approach to re-opening will be heavily influenced by the current Cuyahoga County advisory level.

Level 1	Yellow	Public Emergency: **Active** exposure and spread
Level 2	Orange	Public Emergency: **Increased** exposure and spread
Level 3	Red	Public Emergency: **Very high** exposure and spread
Level 4	Purple	Public Emergency: **Severe** exposure and spread

Level 1	District will consider expanding in-person learning opportunities, including return to a full reopening.
Level 2	District will consider expanding in-person learning opportunities for students.
Level 3	In-person learning hybrid model.
Level 3*	District will consider virtual learning for all students.
Level 4	District will move to virtual learning for all students.

Transmission risk in schools

The CDC indicators and thresholds for risk introduction and transmission in schools are also taken into consideration during the re-opening of schools decision making process.

Regardless of what the indicators determine, the more students or staff who interact and the longer that interaction, the higher the risk of SARS-CoV-2 spread. In general, the risk of SARS-CoV-2 spread in schools increases across the continuum of virtual, hybrid, to in-person learning with the risk moderated for hybrid and in-person learning based upon the range of mitigation strategies put in place and the extent they are correctly and consistently followed.

While not exhaustive, this stratification from Operating schools during COVID-19: CDC's Considerations attempts to characterize the risks of spread among students, teachers, and staff across this continuum:

Lowest risk:

- Students and teachers engage in virtual-only classes, activities, and events

Some risk:

- Hybrid Learning Model: Some students participate in virtual learning and other students participate in in-person learning
- Small, in-person classes, activities, and events
- Cohorting; leveraging all available safe community spaces, including outdoor spaces; alternating schedules, and staggered schedules are applied rigorously
- No mixing of groups of students (i.e., cohorts) and teachers throughout/across school days
- Students and teachers do not share objects
- Students, teachers, and staff always follow all steps to protect themselves and others, including proper use of face masks, social distancing, hand hygiene, and respiratory etiquette
- Regularly scheduled cleaning and disinfection of frequently touched surfaces implemented consistently

CDC indicators and thresholds for risk of introduction and transmission of COVID-19 in schools

INDICATORS	Lowest risk of transmission in schools	Lower risk of transmission in schools	Moderate risk of transmission in schools	Higher risk of transmission in schools	Highest risk of transmission in schools
CORE INDICATORS					
Number of new cases per 100,000 persons within the last 14 days*	<5	5 to <20	20 to <50	50 to ≤ 200	>200
Percentage of RT-PCR tests that are positive during the last 14 days**	<3%	3% to <5%	5% to <8%	8% to ≤ 10%	>10%
Ability of the school to implement 5 key mitigation strategies: • Consistent and correct use of masks • Social distancing to the largest extent possible • Hand hygiene and respiratory etiquette • Cleaning and disinfection • Contact tracing in collaboration with local health department Schools should adopt the additional mitigation measures outlined below to the extent possible, practical and feasible.	Implemented all 5 strategies correctly and consistently	Implemented all 5 strategies correctly but inconsistently	Implemented 3-4 strategies correctly and consistently	Implemented 1-2 strategies correctly and consistently	Implemented no strategies
SECONDARY INDICATORS					
Percent change in new cases per 100,000 population during the last 7 days compared with the previous 7 days (negative values indicate improving trends)	<-10%	-10% to <-5%	-5% to <0%	0% to ≤ 10%	>10%
Percentage of hospital inpatient beds in the community that are occupied***	<80%	<80%	80 to 90%	>90%	>90%

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Medium risk:

- Hybrid Learning Model: Most students participate in in-person learning, some students participate in virtual learning
- Larger in-person indoor classes, activities, and events
- Cohorting, alternating schedules, and staggered schedules are applied with some exceptions
- Some mixing of groups of students (i.e., cohorts) and teachers throughout/across school days
- Students and teachers minimally share objects
- Students, teachers, and staff follow all steps to protect themselves and others such as proper use of face masks, social distancing, hand hygiene and respiratory etiquette
- Regularly scheduled cleaning and disinfection of frequently touched surfaces largely implemented consistently

Higher risk:

- Full sized, in-person classes, activities, and events
- Students minimally mix between classes and activities
- Students and teachers share some objects
- Students, teachers, and staff follow some steps to protect themselves and others at all times such as proper use of face masks, social distancing, hand hygiene and respiratory etiquette
- Irregular cleaning and disinfection of frequently touched surfaces

Highest risk:

- Full sized, in-person classes, activities, and events
- Students mix freely between classes and activities
- Students and teachers freely share objects
- Students, teachers, and staff do not/are not required to follow steps to protect themselves and others such as proper use of face masks, social distancing, hand hygiene and respiratory etiquette
- Irregular cleaning and disinfection of frequently touched surfaces

Youth sports

The more people a child or coach interacts with, the closer the physical interaction, the longer that interaction, and the more sharing of equipment there is by multiple players, the higher the risk of SARS-CoV-2 spread. The risk of spread of the virus that causes COVID-19 increases in youth sports settings as follows:

- Lowest risk: Performing skill-building drills or conditioning at home, alone, or with family members.
- Increasing risk: Team-based practice.
- More risk: Within-team competition.
- Even more risk: Full competition between teams from the same local geographic area.
- Highest risk: Full competition between teams from different geographic areas.

Indicators of Community Transmission (As of March 19, 2021)

School administrators, working with local public health officials, should assess the level of community transmission to understand the burden of disease in the community. The higher the level of community transmission, the more likely that SARS-CoV-2 will be introduced into the school facility from the community, which could lead to in-school transmission if layered prevention strategies are not in use.

CDC recommends the use of two measures of community burden to determine the level of risk of transmission: total number of new cases per 100,000 persons in the past 7 days, and percentage of nucleic acid amplification tests (NAATs), including RT-PCR tests, that are positive during the last 7 days. The two measures of community burden should be used to assess the incidence and spread of SARS-CoV-2 in the surrounding community (for example, county) and not in the schools themselves. If the two indicators suggest different levels, the actions corresponding to the higher threshold (in Table 2) should be chosen. The transmission level for any given location will change over time and should be reassessed weekly for situational awareness and to continuously inform planning and decision-making.

Table 1. CDC Indicators and Thresholds for Community Transmission of COVID-19 (3/19/21)

Indicator	Low Transmission Blue	Moderate Transmission Yellow	Substantial Transmission Orange	High Transmission Red
Total new cases per 100,000 persons in the past 7 days[2]	0-9	10-49	50-99	≥100
Percentage of NAATs that are positive during the past 7 days[3]	<5.0%	5.0%-7.9%	8.0%-9.9%	≥10.0%

[1]If the two indicators suggest different levels, the actions corresponding to the higher threshold should be chosen. County-level data on total new cases in the past 7 days and test percent positivity are available on the County View tab in CDC's COVID Data Tracker.

[2]Total number of new cases per 100,000 persons within the last 7 days is calculated by adding the number of new cases in the county (or other community type) in the last 7 days divided by the population in the county (or other community type) and multiplying by 100,000.

[3]Percentage of positive diagnostic and screening NAATs during the last 7 days is calculated by dividing the number of positive tests in the county (or other administrative level) during the last 7 days by the total number of tests resulted over the last 7 days. Additional information can be found on the Calculating Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Laboratory Test Percent Positivity: CDC Methods and Considerations for Comparisons and Interpretation webpage.

Instructional Model Selection

Due to the elevated health risk posed to students, staff and family members during the COVID-19 pandemic the Cuyahoga County Board of Health (CCBH) issued an initial recommendation that all schools within its health jurisdiction begin the 2020-21 school year remotely. It has been the undertaking of the East Cleveland City School District to follow and build upon this recommendation.

Educational Approaches

The following approaches will be utilized during the "Return-to-school" planning and implementation process:

Approach 1 - Remote Learning

This model is designed for students and families who would like to maintain their connection to EC teachers, but don't yet feel comfortable sending their student(s) back to a traditional school building this coming fall. With EC Virtual Academy, students will attend school remotely, following the standard school schedule and bell times. This learning model will incorporate many of the features that parents and students valued most about instruction this, such as regular virtual real-time interaction with teachers every day for every class. The East Cleveland City School District will start the school year with remote learning for grades K-12.

Student Group	Monday	Tuesday	Wednesday	Thursday	Friday
Remote Learning	Learning at Home	Learning at Home	Learning at Home/Support Services Provided	Learning at Home	Learning at Home

Approach 2 - Hybrid Model

Hybrid Learning: This learning model combines in-person instruction with an element of learning that takes place when students are away from the school setting. This model reduces the number of students in each school building and classroom, to better accommodate Center for Disease Control and Prevention guidelines for social distancing.

Student Group	Monday	Tuesday	Wednesday	Thursday	Friday
Red Team	Learning at Home	Learning at Home	Learning at Home/Support Services Provided	Learning at Home	Learning at Home
Black Team	Learning at Home	Learning at Home	Learning at Home/Support Services Provided	Learning at Home	Learning at Home

PLATO On-Line Coursework

Online Learning Education is a program where students can access coursework that will help them to recover credit and/or to take elective courses to complete graduation requirements. Courses are accessible 24 hours a day, 7 days a week. PLATO content titles are curriculum level learning paths which provide flexibility for all aspects of secondary instruction: remediation, credit recovery, credit accrual, and credit acceleration. Students in grades 9-12 will utilize this method of instruction. (This is still an option while in school and in the remote learning environment)

Student Group	Monday	Tuesday	Wednesday	Thursday	Friday
On-Line Coursework	PLATO Grades 9-12	PLATO Grades 9-12	PLATO Grades 9-12	PLATO Grades 9-12	PLATO Grades 9-12

Essential Elements of Safe K–12 School Operations for In-Person Learning (3/19/21)

Schools are an important part of the infrastructure of communities, as they provide safe and supportive learning environments for students, employ teachers and other staff, and enable parents, guardians, and caregivers to work. Many students, staff, and caregivers are either missing or have had interruptions in services due to school building closures and virtual and hybrid learning. Evidence suggests that many K–12 schools that have strictly implemented prevention strategies have been able to safely open for in-person instruction and remain open.[1]

CDC's Science Brief on Transmission of SARS-CoV-2 in K–12 Schools summarizes evidence on COVID-19 among children and adolescents and what is known about preventing transmission in schools.

CDC has developed guidance for prevention strategies that K–12 school administrators can use to help protect students, teachers, and staff, and slow the spread of COVID-19. If prevention strategies are strictly adhered to, K–12 schools can safely open for in-person instruction and remain open.[1] This document provides an operational strategy for safe delivery of in-person instruction in K–12 schools through the integration of a package of prevention and control components:

1. Consistent implementation of layered prevention strategies to reduce SARS-CoV-2 transmission in schools
2. Consideration of indicators of community transmission to reflect levels of community risk
3. Phased prevention strategies based on levels of community transmission

The following public health efforts provide additional layers of COVID-19 protection in schools:

- Testing to identify individuals with a SARS-CoV-2 infection to limit transmission and outbreaks
- Vaccination for teachers and staff as soon as possible

Health Equity Considerations

Long-standing systemic health and social inequities have put many racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19. People who identify as American Indian/Alaska Native, Black, and Hispanic are disproportionately affected by COVID-19; these disparities have also emerged among children.[1] The absence of in-person educational options might disadvantage children from all backgrounds, particularly children in low-resourced communities who might be at an educational disadvantage. These students might be less likely to have access to technology to facilitate virtual learning and more likely to rely on key school-supported resources such as school meal programs, special education and related services, counseling, and after-school programs. Some parents and caregivers might have less-flexible jobs that do not permit staying at home to provide childcare and aid with virtual learning if schools are closed to in-person instruction. On the other hand, certain racial and ethnic groups have borne a disproportionate burden of illness and serious outcomes from COVID-19. These health disparities are evident even among school-aged children,[1] suggesting that in-person instruction might pose a greater risk of COVID-19 to disproportionately affected populations. For these reasons, health equity considerations related to in-person instruction are an integral part of this complex decision-making. To enable in-person learning in schools that serve racial and ethnic groups disproportionately affected by COVID-19, school administrators and public health officials can work together to help schools plan and implement comprehensive prevention strategies, engage community partners, and assist with referrals to medical care. It is important that these schools have the resources and technical assistance needed to adopt and diligently implement actions to slow the spread of the virus that causes COVID-19 among people inside the school and out in the community. Schools play a critical role in promoting equity in education and health for groups disproportionately affected by COVID-19.

Engagement with educators, families, and the school community

A successful and equitable school reopening strategy requires engaging the entire school community to establish a safe environment for all educators, school staff, and students and promote trust and confidence. School reopening planning should include:

- Administrators
- Teachers
- Student and parent representatives
- Specialized instructional support personnel (such as school counselors, school social workers, school psychologists, and nurses)
- Facilities managers and custodial staff
- Transportation personnel, school nutrition professionals, and family services representatives.

Consistent with health equity considerations, schools and school districts should conduct active and specific outreach to underserved families – including parents/guardians of students of color, students from low-income backgrounds, students with disabilities, English learners, students experiencing homelessness, and students in foster care. This communication should be conducted in families' home languages or mode of communication and in alternate formats as needed to facilitate effective communication for individuals with disabilities and, where appropriate, in partnership with trusted community-based organizations.

2020-2021 Restart Plan

In order to make the transition back to our school buildings, we will incorporate a soft restart process. This will allow us to bring small groups of students into the buildings to get acclimated, meet teachers, and learn the new safety protocols and procedures that are currently in place. If parents/guardians inform the district in writing that they do not want their children to return to school, remote learning is still an option for those students.

The initiation of the Soft Restart Process will be based on multiple sources of information and executed in accordance with the aforementioned Public Health Advisory System's designated level of exposure and spread of COVID-19 in Cuyahoga County. In addition, the recommendations of the Chief Executive Officer/Superintendent of Schools pertaining to how and when we move forward with reopening will be research-based and influenced by a number of factors including:

- Changing health and safety guidelines
- Ohio Reset and Restart Education Planning Guide
- Parent and stakeholder aggregate survey data
- Feasibility of safely reopening schools

Overall, this information will be essential in determining the viability of our return-to-learning plans, and to update our plans accordingly throughout the 2020-21 school year.

Process History

Pre-Kindergarten Face to Face Learning (Started on August 31, 2020)

Pre-Kindergarten

Face to Face Learning (Started on August 31, 2020)					
	Monday	Tuesday	Wednesday	Thursday	Friday
Weekly	Learning in School	Learning in School	Learning from Home/ Support Service Provided	Learning in School	Learning in School

Restart (As of 1/19/2021)

Schools	Grades	Hybrid Model Days
Prospect Academy	Pre-Kindergarten all students	Mon, Tues, Thurs and Fri
Caledonia Elementary	Kindergarten and All Special Education Students (K-2)	Red Team -Monday and Tuesday Black Team - Thursday and Friday
Mayfair Elementary	Fifth and All Special Education Students (3-5)	Red Team -Monday and Tuesday Black Team - Thursday and Friday
W. H. Kirk Middle	Eighth and All Special Education Students (6-8)	Red Team -Monday and Tuesday Black Team - Thursday and Friday
Shaw High	Ninth, Career & Tech and All Special Education Students (9-12)	Red Team -Monday and Tuesday Black Team - Thursday and Friday

Phased Prevention (As of March 19, 2021)

A phased prevention approach for K–12 schools relies on several core concepts.

- **K–12 schools should be the last settings to close after all other prevention measures in the community have been employed, and the first to reopen when they can do so safely.** This implies that decision-makers and communities should prioritize schools for reopening and remaining open for in-person instruction over nonessential businesses and activities, including indoor dining, bars, social gatherings, and close contact sports as community transmission is controlled.
- **In-person instruction should be prioritized over extracurricular activities, including sports and school events, to minimize risk of transmission in schools and protect in-person learning**. Prolonged periods of remote or virtual learning can have negative effects on educational progress for students, potentially slowing or reversing academic gains. Students from low-resourced communities, English learners, and students with disabilities might disproportionately experience learning loss due to limited access to remote learning technology and fewer learning support systems and services outside of schools. Safe in-person schooling can also offset the negative social, emotional, and mental health impacts of prolonged virtual learning. Minimizing the risk of spread during extracurricular activities and social gatherings outside of school can help maintain in-person instruction. Some close-contact sports might not be able to be implemented at any level of community transmission given the risk of transmission and the inability to implement prevention strategies.[1] Schools may consider using expanded screening testing for sports and extracurricular activities to identify cases and reduce risk of transmission from people who are asymptomatic or pre-symptomatic.
- **Lower susceptibility and incidence among younger children compared to teenagers suggests that younger students (for example, elementary school students) are likely to have less risk of in-school transmission due to in-person learning than older students (middle schools and high schools)**. In addition, younger children may benefit more from in-person instruction and are less independent than older students.
- **Families of students who are at increased risk of severe illness (including those with special healthcare needs) or who live with people at high risk should be given the option of virtual instruction, regardless of the mode of learning offered**.
- **Schools are encouraged to use cohorting**, especially in areas of substantial (orange) and high (red) transmission, to facilitate testing and contact tracing, and to minimize transmission across cohorts.

Monitoring levels of community transmission provides school leaders with an indicator system for the risk of introduction of SARS-CoV-2 virus into a school. Information about levels of community transmission should be combined with information about cases in schools and implementation of prevention strategies to guide decision-making. Implementation of prevention strategies should be intensified if indicators worsen (i.e., moving from low to moderate to substantial to high community transmission). Intensifying prevention might also involve imposing restrictions on sports and extracurricular activities to protect in-person learning. To make decisions about preventive actions, school and health officials should take the following information into account:

- The numbers of COVID-19 cases among students, teachers, and staff, and number of people in quarantine
- Compliance with prevention strategies
- Levels of community transmission

Table 2 presents a school operational plan for opening and remaining open that emphasizes layering prevention at all levels of community transmission.

Table 2. Recommended Prevention Strategies for K-12 Schools and Levels of Community Transmission (3/19/21)

<table>
<tr><th colspan="4">Prevention Strategies: All Schools</th></tr>
<tr><td colspan="4">All schools implement 5 key prevention strategies:
Universal and correct use of masks required
Physical distancing
Handwashing and respiratory etiquette
Cleaning and maintaining healthy facilities
Contact tracing in combination with isolation and quarantine</td></tr>
<tr><th colspan="4">Prevention Strategies by Level of Community Transmission</th></tr>
<tr><th>Low Transmission[1]
Blue</th><th>Moderate Transmission
Yellow</th><th>Substantial Transmission
Orange</th><th>High Transmission
Red</th></tr>
<tr><td colspan="2">Elementary Schools
Physical distancing: at least 3 feet between students in classrooms</td><td colspan="2">Elementary Schools
Physical distancing: at least 3 feet of distance between students in classrooms
Cohorting[2] recommended when possible</td></tr>
<tr><td colspan="2">Middle and High Schools
Physical distancing: at least 3 feet between students in classrooms</td><td>Middle and High Schools
Physical distancing: at least 3 feet of distance between students in classrooms
Cohorting recommended when possible</td><td>Middle and High Schools
Schools that can use cohorting: at least 3 feet of distance
Schools that cannot use cohorting: at least 6 feet distance between students in classrooms [2]</td></tr>
<tr><td>Sports and extracurricular activities
Sports and extracurricular activities occur with at least 6 feet of physical distance to the greatest extent possible[6]</td><td>Sports and extracurricular activities
Sports and extracurricular activities occur with at least 6 feet of physical distance required[6]</td><td colspan="2">Sports and extracurricular activities
Sports and extracurricular activities occur only if they can be held outdoors, with more than 6 feet of physical distancing[6]</td></tr>
</table>

[1]Levels of community transmission defined as total new cases per 100,000 persons in the past 7 days (low, 0-9; moderate, 10-49; substantial, 50-99; high, ≥100) and percentage of positive tests in the past 7 days (low, <5%; moderate, 5-7.9%; substantial, 8-9.9%; high, ≥10%).

[2]Cohorting involves creating groups of students that are separated from other groups by at least 6 feet throughout the entire day. Cohorting can be implemented in either full in-person instruction or hybrid instruction, or through other strategies.
[3]In middle and high schools, 6 feet is recommended in areas of high community transmission, unless they can implement cohorting. Schools may consider using reduced attendance, hybrid instruction, or other strategies to ensure 6 feet of physical distance between students in middle and high schools that do not use cohorting. Diagnostic testing for SARS-CoV-2 is intended to identify occurrence of SARS-CoV-2 infection at the individual level and is performed on individuals with or without suspected COVID-19 infection in accordance with the test's authorization and labeling.
[4]Middle and high schools in areas of high community transmission should implement cohorting if they use less than 6 feet between students in classrooms. If cohorting is not possible, 6 feet between students is recommended. Middle and high schools can use strategies such as reduced attendance (some students are virtual only at all times) or hybrid instruction to achieve 6 feet of distance.
[5]School officials should implement limits on spectators and attendees for sports, extracurricular activities, and events to ensure 6 feet of physical distance and require use of masks.
[6]Schools may consider using screening testing for student athletes and adults (e.g., coaches, trainers) who support these activities to facilitate safe participation and reduce risk of transmission. See screening testing section and Table 4 for additional details.

Monitoring cases and making decisions about in-person instruction

The East Cleveland City Schools will closely and regularly monitor the numbers of students, teachers, and staff with COVID-19, as well those in isolation and in quarantine. In collaboration with the local health department, decisions will combine information about levels of community transmission with school-specific factors, such as implementation of prevention strategies and the number of cases among students, teachers, and staff. Schools may consider convening a team or committee with representation from local public health and members of the school community (for example, students, parents, teachers, and staff) to review data regularly, share information, and discuss opportunities to support open communication with school stakeholders. As levels of community transmission increase, schools should further strengthen prevention strategies and monitor cases to reassess decisions.

Interventions to control clusters

A school **cluster** is an index case and two or more cases epidemiologically linked to the index case who likely acquired SARS-CoV-2 infection in school (i.e., school-associated cases). When cases are introduced into the school environment, they can lead to clusters and potentially to rapid and uncontrolled spread. This is more likely to happen in areas of substantial or high community transmission, as cases are more likely to be introduced into the school from the community. As a district we will monitor cases (consistent with privacy and other applicable laws), identify clusters quickly, and promptly intervene to control spread. Infection source and whether the infection is likely acquired in school or outside of school should be determined by case investigations conducted by a collaboration between school administration and the local health department.

The East Cleveland City Schools will take the following actions to control transmission in the event of a cluster:

1. Investigate cases and trace contacts; encourage isolation and quarantine (consistent with applicable privacy and other laws).
    - Work with the health department to carefully investigate each case, including conducting interviews with students, teachers, parents, and school staff.
    - Encourage compliance with isolation for people who test positive.
    - Work with the health department to trace close contacts in accordance with applicable federal and state privacy laws of all cases and refer close contacts for diagnostic testing. Encourage compliance with quarantine.
2. Assess situations where close contacts occurred and implement interventions to address potential contributors to the clusters. For example:
    - Determine whether inconsistent or incorrect use of masks contributed to the clusters and intervene to improve consistent and correct mask use.
    - Assess implementation of physical distancing and determine whether intervention is needed to address distancing.

- Eliminate or decrease nonessential in-person interactions among teachers and staff during meetings, lunches, and other situations that may have led to adult-to-adult transmission.

Unplanned school closures

Despite careful planning and consistent implementation of prevention strategies, some situations may lead school officials to consider temporarily closing schools or parts of a school (such as a class, cohort, or grade level) to in-person instruction, typically in consultation with the local health department. These decisions will be made based on careful consideration of a variety of factors and with the emphasis on ensuring the health and wellness of students, their families, and teachers and staff. In such cases, the District will make efforts to provide continuity of instruction through synchronous remote learning or at-home activities.

Classrooms, cohorts, or schools experiencing uncontrolled spread of COVID-19 may temporarily close for in-person learning. If the school is experiencing uncontrolled spread, District leaders will immediately notify public health officials and collaborate to facilitate increased testing and contact tracing, as necessary. The local health department may facilitate testing for students, teachers, and staff who are in schools with an uncontrolled spread. The same is true for schools in areas experiencing rapid or persistent rises in COVID-19 case rates or severe burden on health care capacity.

School leaders and public health officials will monitor indicators of community transmission (Table 1) and review trends over time. In communities that have rapid or persistent rises in COVID-19 incidence or severe healthcare capacity burden, school leaders may decide to temporarily close schools to in-person instruction until levels of community transmission stabilize.

Providing options for teachers and school staff

At all levels of community transmission, employers should provide reassignment, remote work, or other options for teachers and staff who have documented high-risk conditions that place them at increased risk for severe illness from COVID-19 to limit the risk of workplace exposure. When these conditions are disabilities under the Americans with Disabilities Act, employers should ensure compliance with law and may need to consider providing reasonable accommodation subject to undue hardship. Options for reassignment **may** include but are not limited to telework, virtual teaching opportunities, modified job responsibilities, environmental modifications, scheduling flexibility, or temporary reassignment to different job responsibilities. These options should likewise be extended to teachers and staff who have a household member who is at increased risk for severe illness from COVID-19. Policies and procedures addressing issues related to teachers and staff at higher risk of serious illness and the application of reassignment, remote work, or other options for prevention should be made in consultation with occupational medicine and human resource professionals with knowledge of the specific situation, keeping in mind Equal Employment Opportunity (EEO) and other potential legal concerns. Schools should work with local counsel to ensure compliance.

New COVID-19 variants and prevention in schools

Multiple SARS-CoV-2 variants are circulating globally. These include several variants that have been detected in the United States. Some of these variants seem to spread more easily and quickly than other variants, which could lead to more cases of COVID-19. Rigorous implementation of prevention strategies is essential to control the spread of variants of SARS-CoV-2. CDC, in collaboration with other public health agencies, is monitoring the situation closely and studying these variants quickly to learn more to control their spread. As more information becomes available, prevention strategies and school guidance may need to be adjusted to new evidence on risk of transmission and effectiveness of prevention in variants that are circulating in the community.

Health equity considerations in phased prevention

- Schools that serve student populations that are at greater risk for learning loss during virtual instruction (for example, due to their more limited access to technology) should be prioritized for providing in-person instruction and be provided the needed resources to implement prevention.
- Schools should consider prioritizing in-person instruction for students with disabilities who require special education and related services directly provided in school environments, as well as other students who may benefit from receiving essential instruction in a school setting.
- Schools should develop plans to continue meal service provision, such as free breakfast and lunch to families for every learning mode, including in-person, hybrid, and virtual.

Additional COVID-19 Prevention Strategies (As of March 19, 2021)

Testing

Viral testing strategies in partnership with schools should be part of a comprehensive prevention approach. Testing should not be used alone, but in combination with other prevention to reduce risk of transmission in schools. When schools implement testing combined with prevention strategies, they can detect new cases to prevent outbreaks, reduce the risk of further transmission, and protect students, teachers, and staff from COVID-19.

Diagnostic Testing

At all levels of community transmission, schools should offer referrals to diagnostic testing to any student, teacher, or staff member who is exhibiting symptoms of COVID-19 at school. Diagnostic testing for SARS-CoV-2 is intended to identify occurrence of SARS-CoV-2 infection at the individual level and is performed when there is a reason to suspect that an individual may be infected, such as having symptoms or suspected recent exposure. Examples of diagnostic testing strategies include testing symptomatic teachers, students, and staff who develop symptoms in school, and testing asymptomatic individuals who were exposed to someone with a confirmed or suspected case of COVID-19. Additional considerations for diagnostic testing:

- Schools should advise students, teachers, and staff to stay home if they are sick or if they have been exposed to SARS-CoV-2. Schools can encourage these individuals to talk to their healthcare provider about getting a COVID-19 test.
- If a student, teacher, or staff member becomes sick at school or reports a new COVID-19 diagnosis, schools should follow the steps of the COVID-19 Diagnosis flowchart on what to do next. This includes notifying a student's parent or guardian and initiating testing strategies. Notifications must be accessible for all students, parents, or guardians, including those with disabilities or limited English proficiency (for example, through use of interpreters or translated materials).
- In some schools, school-based healthcare professionals (for example, school nurses) may perform SARS-CoV-2 antigen testing in school-based health centers if they are trained in specimen collection, conducting the test per manufacturer's instructions, and obtain a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiverexternal icon. Some 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 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).
- Not every school or school-based healthcare professional will have the staff, resources, or training to conduct testing. Public health officials should work with schools to help link students and their families, teachers, and staff to other opportunities for testing in their community. Testing could be offered by referral to community-based testing sites, through collaboration with local public health, or through a centralized test location offered by the school district.

The presence of any of the symptoms below generally suggests a student, teacher, or staff member has an infectious illness and should not attend school, regardless of whether the illness is COVID-19. For students, staff, and teachers with chronic conditions, symptom presence should represent a change from their typical health status to warrant

exclusion from school. Occurrence of any of the symptoms below while a student, teacher, or staff member is at school suggests the person may be referred for diagnostic testing.

- Temperatureexternal iconof 100.4 degrees Fahrenheit or higher
- Sore throat
- Cough (for students with chronic cough due to allergies or asthma, a change in their cough from baseline)
- Difficulty breathing (for students with asthma, a change from their baseline breathing)
- Diarrhea or vomiting
- New loss of taste or smell
- New onset of severe headache, especially with a fever

Students should not attend school in-person if they or their caregiver identifies new development of any of the symptoms above.

Schools can provide options to separate students with COVID-19 symptoms or suspected or confirmed COVID-19 diagnoses by, for example, placing students in isolation room/areas until transportation can be arranged to send them home or seek emergency medical attention.

If a COVID-19 diagnosis is confirmed, schools can support public health officials in determining which close contacts and other potentially exposed persons in the school setting could be tested and either isolated or quarantined (see Table 3). Schools can assist by providing information, where appropriate, to identify close contacts (for example, class rosters, seating charts, and information to facilitate outreach to contacts).

Table 3. Tiered approach of diagnostic testing for SARS-CoV-2[1,2]

Students, teachers, and staff with symptoms of COVID-19 **Refer for diagnostic testing**	Students, teachers, or staff with symptoms of COVID-19 at school, at all levels of community transmission. • Individuals with positive test results should go to their home and isolate until they have met criteria for release from isolation. People with symptoms should be isolated away from others as soon as symptoms appear and sent home. Those with positive test results should remain in isolation until they have met all three criteria for release: 10 days have passed since symptom onset; at least 24 hours have passed since resolution of fever without medication; and other symptoms have improved. CDC does not recommend that people be tested again before leaving isolation because people who have recovered can test positive for several weeks without being contagious. If an individual with symptoms tests negative, they should still stay home until their symptoms resolve to avoid spreading any SARS-CoV-2 or other infection.
Close contacts **Refer for diagnostic testing**	Students, teachers, or staff who had contact with someone diagnosed with COVID-19, defined as someone who has been within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period. The definition of a close contact applies regardless of whether either person was wearing a mask. The definition also applies in schools that use less than 6 feet between students in classrooms. Families of close contacts should be notified and referred for testing immediately. • Regardless of the test result, close contacts should quarantine for 14 days. Based on local circumstances and resources, options to shorten quarantine provide acceptable alternatives of a 10-day quarantine or a 7-day quarantine combined with testing. • To minimize impact of quarantines on delivery of instruction, schools should limit the potential for exposures across cohorts and classrooms (for example, teachers should limit close contacts with other teachers and with students not in their own classrooms). People who are fully vaccinated or were previously diagnosed with COVID-19 within the last three months may not need to quarantine.

[1]The tiers above are intended to be applied across all levels of community transmission: low (blue), moderate (yellow), substantial (orange), and high (red).

[2] information should be provided with appropriate safeguards to protect personally identifiable information and HIPPA-sensitive information from unlawful release.

For diagnostic testing, selection of tests should prioritize tests with highly accurate results with high sensitivity and specificity such as NAATs. Referral to diagnostic testing for students, teachers, and staff who have symptoms of COVID-19 at school and for close contacts is recommended for all levels of community transmission. Students, teachers, and staff who have diagnostic testing performed should be isolated away from others and quarantined at home until test results are received. Diagnostic testing turnaround times depend on the type of test and the laboratory conducting it. Local capacity in diagnostic tests should ensure that people with suspected COVID-19 and their contacts are tested with results returning within 48 hours. At low levels of community transmission (blue), schools should refer students, teachers, and staff with symptoms or recent history of close contact with a confirmed case for diagnostic testing to identify or rule out SARS-CoV-2 infection. At moderate (yellow), substantial (orange), and high (red) levels, and at low (blue) levels for teachers and staff, referral to diagnostic testing is combined with screening testing to monitor any increases in infection rates.

For students, teachers, and staff who had previously received positive test results and do not have symptoms of COVID-19, retesting is not recommended for up to 3 months from their last positive test result. Data currently suggest that some individuals persistently test positive due to residual virus material but are unlikely to be infectious. Parents or guardians can request documentation from their healthcare provider to indicate the date and type of the student's most recent COVID-19 test. Guidance on testing strategies for people who are fully vaccinated will be updated as more information becomes available. As vaccine supply increases and more teachers and staff receive vaccine, CDC's priorities for SARS-CoV-2 testing will change and the guidance will be updated.

Screening Testing

Some schools may also elect to use screening testing as a strategy to identify cases and prevent secondary transmission. Screening testing involves using SARS-CoV-2 viral tests (diagnostic tests used for screening purposes) intended to identify occurrence at the individual level even if there is no reason to suspect infection—i.e., there is no known exposure and no symptoms. This includes, but is not limited to, screening testing of asymptomatic people without known exposure with the intent of making decisions based on the test results. Screening testing is intended to identify infected people without symptoms (or before development of symptoms) who may be contagious so that measures can be taken to prevent further transmission. The intent is to use the screening testing results to determine who may return to in-person school or work and the protective measures that will be taken, and to identify and isolate positive persons to prevent spread.

Screening testing is particularly valuable in areas with moderate, substantial, and high levels of community transmission. Screening testing for K–12 schools may allow schools to move between different testing strategies as community prevalence (and therefore risk assessment) changes. Screening testing could provide added protection for schools that use less than 6 feet of physical distancing between students in classrooms. For schools that implement it, screening testing should be offered at moderate (yellow), substantial (orange), and high (red) levels of community transmission, to students, teachers, and staff, and at low (blue) levels to teachers and staff. Achieving substantial reduction in transmission with testing requires more frequent testing and shorter lags between test administration and reporting of results.

Schools may consider using pooled testing as a screening testing strategy for students. Pooled testing involves mixing several samples from different individuals together in a "batch" or pooled sample, then testing the pooled sample with a diagnostic test. This approach increases the number of individuals that can be tested and reduces the need for testing resources. This approach may be particularly helpful in schools using cohorts. Because of the complexities of acting on a positive result, pooled testing is best used in situations where the number of positives is expected to be very low. Cohorts could be established in grade groups, such as all students in a particular grade or in similar grades (for example, K–grade 2; grades 3–5). If a confirmed positive case is found, close contacts of anyone in that cohort should be quarantined and tested.

Table 4. Testing Recommendations by Level of Community Transmission

<table>
<tr><td colspan="4">Testing Recommendations: All Schools</td></tr>
<tr><td colspan="4">Diagnostic testing[1]: Symptomatic students, teachers, and staff and close contacts referred for diagnostic testing

Screening Testing for teachers and staff: expanded screening testing[3] of teachers and staff offered at least once per week</td></tr>
<tr><td colspan="4">Testing Recommendations by Level of Community Transmission</td></tr>
<tr><td>Low Transmission[1]

Blue</td><td>Moderate Transmission

Yellow</td><td>Substantial Transmission

Orange</td><td>High Transmission

Red</td></tr>
<tr><td>No screening testing for students</td><td colspan="3">Screening testing for students: expanded screening testing of students [4] offered at least once per week</td></tr>
<tr><td colspan="2">Testing for high-risk sports:[5] for schools conducting routine testing for sports, testing is recommended at least once per week</td><td colspan="2">Testing for high-risk sports: for schools conducting routine testing for sports, testing is recommended twice per week</td></tr>
<tr><td colspan="2">Testing for low and intermediate-risk sports: for schools conducting routine testing for sports, testing is recommended at least once per week</td><td colspan="2">Testing for low and intermediate-risk sports: for schools conducting routine testing for sports, testing is recommended at least once per week</td></tr>
</table>

[1]Diagnostic testing for SARS-CoV-2 is intended to identify occurrence of SARS-CoV-2 infection at the individual level and is performed when there is a reason to suspect that an individual may be infected, such as having symptoms or suspected recent exposure.

[1]Screening testing is intended to identify infected asymptomatic individuals who may be contagious so that measures can be taken to prevent further transmission.

[3]Levels of community transmission defined as total new cases per 100,000 persons in the past 7 days (low, 0-9; moderate, 10-49; substantial, 50-99; high, ≥100) and percentage of positive tests in the past 7 days (low, <5%; moderate, 5-7.9%; substantial, 8-9.9%; high, ≥10%).

[4]Schools may consider testing a random sample of at least 10% of students or may conduct pooled testing of cohorts/pods for screening testing in areas of moderate and substantial community transmission.

[5]Schools may consider using screening testing for student athletes and adults (e.g., coaches, teacher advisors) who support these activities to facilitate safe participation and reduce risk of transmission. For an example risk stratification for sports, see https://ncaaorg.s3.amazonaws.com/ssi/COVID/SSI_ResocializationDevelopingStandardsSecondEdition.pdfpdf iconexternal icon.

When combined with prevention measures, such as mask use, physical distancing, and others, testing protocols might be an effective tool in reducing transmission. Screening testing can be administered directly at a school facility (see Feasibility considerations section below), at a central location through the school district, or through referral to community-based testing providers.

- **Moderate (yellow), substantial (orange), and high (red) community transmission**: Students, teachers, and staff participate in regular screening testing to reduce the risk of transmission within the school.
    - Teachers and staff participate in routine screening testing at least once per week. In areas with substantial and high community transmission, twice a week screening testing might be preferable to quickly detect cases among teachers and staff.
    - Students in elementary, middle, and high schools participate in routine screening testing at least once per week. If a confirmed positive case is found, any close contacts are quarantined and tested.
    - Schools might consider testing a random sample of at least 10% of students. For example, a school might randomly select 20% of the students each week for testing out of the entire population of students attending in-person instruction. Alternatively, a school might select one cohort for each grade level each week for testing. Different strategies for random selection can be used based on most adequate fit for a school screening testing strategy.

- **Screening testing for sports**: To facilitate safe participation in sports and reduce transmission in activities that have elevated risk, schools may consider requiring screening testing for participation. Schools can implement testing among student athletes/participants, coaches, and trainers, and any other individuals (such as parent volunteers) who could come into close contact with others during these activities.
    - Sports events, competitions, and activities could include universal screening testing the day of the event or one day before.
    - Low and intermediate risk sports[3] include those that can be conducted outdoors, or indoors with masks. Testing at least once per week is recommended for these sports.
    - High-risk sports[3] include those that cannot be done outdoors or with masks. Testing twice per week in areas of low, moderate, and substantial community transmission is recommended for participation in these sports. High-risk sports should be virtual or canceled in areas of high community transmission.

When considering which tests to use for screening testing, schools or their testing partners should choose tests that can be reliably supplied and that provide results within 24 hours. NAATs are high-sensitivity tests for detecting SARS-CoV-2 nucleic acid. Most NAATs need to be processed in a laboratory with variable time to results (could be 1–3 days), but some NAATs are point-of-care tests with results available in about 15 minutes. Pooled testing—in which samples from multiple people are initially combined—may reduce costs and turn-around times. These may be considered for at least weekly screening testing in areas of moderate (yellow) community transmission.

Antigen tests are generally less sensitive than NAATs, and most can be processed at the point-of-care with results available in about 15 minutes. Antigen test results might need confirmation with a NAAT in certain circumstances, such as a negative test in persons with symptoms or a positive test in persons without symptoms. Schools should work with the health department to develop a confirmation and referral plan before implementing testing. The immediacy of results (test results in 15–30 minutes), modest costs, and feasibility of implementation of antigen tests make them a reasonable option for school-based screening testing. The feasibility and acceptability of tests that use nasal (anterior nares) swabs make these types of tests more readily implemented in school settings. Tests that use saliva specimens might also be acceptable alternatives for younger children, if tests are available and results are returned within 24 hours.

Taking into consideration the potential for limited availability of supplies for screening testing or feasibility of implementing screening testing, schools should consider a prioritization strategy.

- Schools and public health officials might consider prioritizing teachers and staff over students given the increased risk of severe illness among certain adults.
- In selecting among students, schools and public health officials might prioritize high school students, then middle school students, and then elementary school students, reflecting higher infection rates among adolescents compared to younger children.

Reporting test results

Every COVID-19 testing site is required to report to the appropriate state or local health officials all diagnostic and screening tests performed. Schools that use antigen testing must apply for and receive a Clinical Laboratory Improvement Amendments (CLIA)external icon certificate of waiver, and report test results to state or local public health departments as mandated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136).

Parents should be asked to report positive cases to schools to facilitate contact tracing and ensure communication and planning in schools. In addition, school administrators should notify staff, teachers, families, and emergency contacts or legal guardians immediately of any case of COVID-19 while maintaining confidentiality in accordance with

the Health Insurance Portability and Accountability Act of 1996 (HIPAAexternal icon), the Americans with Disabilities Act (ADAexternal icon), and the Family Educational Rights and Privacy Act (FERPApdf iconexternal icon), and other applicable laws and regulations. Notifications must be accessible for all students, teachers, and staff, including those with disabilities or limited English proficiency (for example, through use of interpreters or translated materials).

Health equity considerations in school-based testing

Public health officials and school administrators should consider placing a higher priority for access to testing in schools that serve populations experiencing a disproportionate burden of COVID-19 cases or severe disease. These might include:

- Schools in communities that have experienced disproportionately high rates of COVID-19 cases relative to population size, which may include communities with moderate or large proportions of racial and ethnic groups, such as American Indian/Alaska Native, Black, and Hispanic persons.
- Schools in geographic areas with limited access to testing due to distance or lack of availability of testing[25].

Ethical considerations for school-based testing

Testing should not be conducted without informed consent from the individual being tested (if an adult) or the individual's parent or guardian (if a minor). Informed consent requires disclosure, understanding, and free choice and is necessary for teachers and staff (who are employees of a school) and students' families to act independently and make choices according to their values, goals, and preferences. Differences in position and authority (i.e., workplace hierarchies), as well as employment and educational status, can affect an individual's ability to make free decisions. CDC provides guidance and information related to consent for COVID-19 testing among employees. These considerations also apply and can be adapted to school-based testing.

Schools should make a communication plan to notify local health officials, staff, and families immediately of any case of COVID-19 while maintaining confidentiality in accordance with the Americans with Disabilities Act (ADA) external iconand Family Educational Rights and Privacy Act (FERPA)external icon, the Protection of Pupil Rights Amendment (PPRA)external icon, and other applicable laws and regulations. Collaboration with local counsel, education, or public health is recommended to ensure appropriate consent is obtained and maintained and results are retained with appropriate privacy and confidentiality.

Considerations before starting any testing strategy

Before implementing testing in their schools, K–12 school leaders should coordinate with public health officials to ensure there is support for this approach from students, parents, teachers, and staff and to develop a testing plan that has key elements in place, including:

- Dedicated infrastructure and resources to support school-based testing.
- Use of tests that are authorized by FDA for the specific intended use (i.e., screening, pooling), and a mechanism in place for prescriptions/test orders by a licensed healthcare provider.
- CLIA certificate of waiver requirements to perform school-based testing with Emergency Use Agreement-authorized tests.
- A mechanism to report all testing results (both positive and negative) as required by the state or local health department.
- Ways to obtain parental consent for minor students and assent/consent for the students themselves.
- Physical space to conduct testing safely and privately.
- Ability to maintain confidentiality of results and protect student and staff privacy.
- Plans for ensuring access to confirmatory testing when needed through the state or local health department for symptomatic persons who receive a negative test result and asymptomatic persons who receive a positive test result.

If these elements are not in place, schools may consider a referral-based testing strategy in collaboration with public health officials.

The East Cleveland City Schools will continue to work with local public health officials to decide whether and how to use testing. K–12 schools operated by the federal government (for example, for Department of Defense Education Activity [DoDEA], which operates K–12 schools for DoD Dependents) should collaborate with federal health officials. In addition to state and local laws, school administrators should follow guidance from the Equal Employment Opportunity Commissionexternal icon, and applicable federal laws when offering testing to faculty, staff, and students who are employed by the K–12 school.

Feasibility considerations and challenges of school-based testing

These challenges must be considered carefully and addressed as part of plans for school-based testing developed in collaboration with public health officials.

- In some schools, school-based healthcare professionals (for example, school nurses) can perform COVID-19 viral testing if the school or test site receives a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiverexternal icon. Some school-based healthcare professionals might also be able to perform specimen collection to send to a lab for testing, if trained in specimen collection, without a CLIA certificate. It is important that school-based health care professionals have access to, and training on the proper use of personal protective equipment (PPE). Facilities should be aware of the FDA EUA external iconfor antigen tests external iconand the Center for Medicare & Medicaid (CMS's) enforcement discretion pdf iconexternal iconregarding the CLIA external iconcertificate of waiver when using tests in asymptomatic individuals.
- Not every school system will have the staff, resources, or training (including the CLIA certificate of waiver) to conduct testing. Public health officials should work with schools to help link students and their families, teachers, and staff to other opportunities for testing in their community.
- School-based testing might require a high degree of coordination and information exchange among health departments, schools, and families.
- There might also be legal and regulatory factors to consider with onsite school-based testing regarding who will prescribe the tests, who will administer the tests, how tests will be paid for, and how results will be reported. Such factors include local or state laws defining the services school nurses and other school-based health professionals are permitted to provide, as well as applicable privacy laws.
- The benefits of school-based testing need to be weighed against the costs, inconvenience, and feasibility of such programs to both schools and families.
- Antigen tests usually provide results diagnosing an active SARS-CoV-2 infection faster than NAATs. However, antigen tests have a higher chance of missing an active infection even in symptomatic people, and confirmatory molecular testing might be recommended.

Vaccination for teachers and staff, and in communities as soon as supply allows

Vaccines are an important tool to help stop the COVID-19 pandemic. Teachers and staff hold jobs critical to the continued functioning of society and are at potential occupational risk of exposure to SARS-CoV-2. Vaccinating teachers and staff is one layer of prevention and protection for teachers and staff. Strategies that minimize barriers to access vaccination for teachers and other frontline essential workers, such as vaccine clinics at or close to the place of work, are optimal. To address this important public health priority, the Health and Human Services Secretary issued a Secretarial Directivepdf iconexternal icon on March 2, 2021, that directs all COVID-19 vaccination providers administering vaccine purchased by the US government to make vaccines available to those who work in K–12 schools. This means that in addition to existing state and local COVID-19 vaccination sites, teachers and staff in schools across the nation can sign up for an appointment at more than 9,000 pharmacy locations participating in the Federal Retail Pharmacy Program for COVID-19 Vaccination.

New CDC resources are available to provide information about this directive:

- The COVID-19 Vaccines for Teachers, School Staff, and Childcare Workers web page provides school and childcare staff with the latest information about where and how to book an appointment.
- The COVID-19 Vaccine Toolkit for School Settings and Childcare Programs provides schools and childcare programs with ready-made materials they can use to communicate with staff about COVID-19 vaccination.

School officials and health departments can work together to also support messaging and outreach about vaccination for members of school communities. School communication platforms can facilitate outreach to encourage vaccination of household members of school-age children as they become eligible. This should include outreach in a language that limited English proficient family members of students can understand and in alternate formats as needed to facilitate effective communication for individuals with disabilities.

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

Definitions

- **School staff** in this document refers to any school employees, contractors, or independent consultants interacting with students or teachers during the course of the school day, including, for example, school administration, bus drivers, school nutrition professionals, school nurses, speech/occupational therapists, custodians, and other school employees.

References

1. https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/transmission_k_12_schools.html
2. American Academy of Pediatrics. COVID-19 Guidance for Safe Schools. January 5, 2021. https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools/external icon
3. For an example classification scheme for risk of transmission in sports, see https://ncaaorg.s3.amazonaws.com/ssi/COVID/SSI_ResocializationDevelopingStandardsSecondEdition.pdfpdf iconexternal icon
4. Doyle T et al. COVID-19 in Primary and Secondary School Settings During the First Semester of School Reopening – Florida, August-December, 2020. MMWR 2021; March 19, 2021.
5. Hershow RB et al. Low SARS-CoV-2 Transmission in Elementary Schools – Salt Lake County, Utah, December 3, December 3, 2020-January 31, 2021. MMWR 2021; March 19, 2021.
6. Volpp KG et al. Minimal SARS-CoV-2 Transmission Following Implementation of a Comprehensive School Mitigation Strategy – New Jersey, August 20-November 27, 2020. MMWR 2021; March 19, 2021.

We are COVID Ready

Prevention Strategies to Reduce Transmission of SARS-CoV-2 in Schools (as of March 19, 2021)

Regardless of the level of community transmission, it is critical that schools use and layer prevention strategies. Five key prevention strategies are essential to safe delivery of in-person instruction and help to prevent COVID-19 transmission in schools:

1. Universal and correct use of masks
2. Physical distancing
3. Handwashing and respiratory etiquette
4. Cleaning and maintaining healthy facilities
5. Contact tracing in combination with isolation and quarantine

Schools providing in-person instruction should prioritize two prevention strategies:

1. Universal and correct use of masks should be required

2. Physical distancing should be maximized to the greatest extent possible.

All prevention strategies provide some level of protection, and layered strategies implemented at the same time provide the greatest level of protection. Schools should adopt prevention strategies to the largest extent practical—a layered approach is essential.

Health equity considerations in prevention strategies

Federal and state disability laws, to the extent applicable, require an individualized approach for students with disabilities consistent with the student's IEP or Section 504 plan. Educators and school leaders must remain aware of their obligations under federal and state disability laws and should also consider adaptations and alternatives to prevention strategies, while maintaining efforts to protect students, teachers, and staff from COVID-19.

CDC's K–12 Schools COVID-19 Prevention Toolkitpdf icon includes resources, tools, and checklists to help school administrators and school officials prepare schools to open for in-person instruction and to manage ongoing operations. These tools and resources include considerations for addressing health equity, such as class sizes, internet connectivity, access to public transportation, etc.

Universal and correct use of masks

East Cleveland City Schools Face Coverings Policy (V) (as of 9/15/20)

Because of the importance of face masks in slowing the spread of COVID-19, the **District has established a face covering policy that takes into consideration** all the available science at the time of its development. As new information is discovered the policy will be updated accordingly.

- **Fact: Use of cloth face coverings can reduce the spread of respiratory droplets that, in infected people, carry and spread COVID-19.**
- The District is mandating that all employees and all students in K through 12 wear a face covering unless they are unable to do so for health or developmental reasons.

Transportation Considerations (Face Coverings)

Students who are being transported to school via school buses are at increased risk for transmission by nature of being in an enclosed space for an extended period of time. Additionally, buses often transport children from multiple grade levels from different parts of the community.

The District requires all students to wear a face covering while being transported on school buses.

Core principle for masks: Require consistent and correct use of well-fitting face masks with proper filtration by all students, teachers, and staff to prevent SARS-CoV-2 transmission through respiratory droplets. Masks should be worn at all times, by all people in school facilities, with certain exceptions for certain people, or for certain settings or activities, such as while eating or drinking. Masks should be required in all classroom and non-classroom settings, including hallways, school offices, restrooms, gyms, auditoriums, etc.

- **Mask policies:** All students, teachers, and staff are expected to wear masks throughout the school.
- The most effective fabrics for cloth masks are tightly woven, such as cotton and cotton blends, breathable, and in two or three fabric layers. Masks with exhalation valves or vents, those that use loosely woven fabrics, and those that do not fit properly are not recommended.
- Most students, including those with disabilities, can tolerate and safely wear a mask. However, a narrow subset of students with disabilities might not be able to wear a mask or cannot safely wear a mask. Those who cannot safely wear a mask—for example, 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—should not be required to wear one. For the remaining portion of the subset, schools should make individualized determinations as required by Federal disability laws in order to determine if an exception to the mask requirement is necessary and appropriate for a particular student. If a child with a disability cannot wear a mask, maintain physical distance, or adhere to other public health

requirements, the student is still entitled to an appropriate education, which in some circumstances may need to be provided virtually.

- Mask use should be required on school buses and other public transportation; school systems should take appropriate steps to ensure compliance with this requirement by students, staff, and others.
- If visitors are permitted in school, they should be required to wear masks at all times and should maintain physical distance from others.
- Schools should encourage modeling of correct and consistent mask use by school leaders, local leaders, and others respected in the community.

Physical distancing

Core principle for physical distancing: Establish school policies and implement structural interventions to promote physical distance between people.

- Between students in classrooms
    - In elementary schools, students should be at least 3 feet apart.1
    - In middle schools and high schools, students should be at least 3 feet apart in areas of low, moderate, or substantial community transmission. In areas of high community transmission, middle and high school students should be 6 feet apart if cohorting is not possible.1,2, 4-6
- Maintain 6 feet of distance in the following settings:
    - Between adults (teachers and staff), and between adults and students, at all times in the school building. Several studies have found that transmission between staff is more common than transmission between students and staff, and among students, in schools.1
    - When masks cannot be worn, such as when eating.
    - During activities when increased exhalation occurs, such as singing, shouting, band, or sports and exercise. Move these activities outdoors or to large, well-ventilated space, when possible.
    - In common areas such as school lobbies and auditoriums.
- Use cohorting, and maintain 6 feet of distance between cohorts where possible. Limit contact between cohorts. In areas of substantial (orange) and high (red) levels of community transmission, schools that use less than 6 feet between students in classrooms, cohorting is recommended, with at least 6 feet maintained between cohorts.
- Remove nonessential furniture and make other changes to classroom layouts to maximize distance between students.
- Face desks in the same direction, where possible.
- Eliminate or decrease nonessential in-person interactions among teachers and staff during meetings, lunches, and other situations that could lead to adult-to-adult transmission.
- Visitors: Limit any nonessential visitors, volunteers, and activities involving external groups or organizations as much as possible—especially with people who are not from the local geographic area (for example, not from the same community, town, city, county). Require all visitors to wear masks and physically distance from others.
- Transportation: Create distance between children on school buses (for example, seat children one child per row, skip rows), when possible. Masks are required by federal order on school buses and other forms of public transportation in the United States. Open windows to improve ventilation when it does not create a safety hazard. More information about school transportation and prevention is available.

Additional suggestions for physical distancing:

- Staggered scheduling: Stagger school arrival and drop-off times or locations by cohort, or put in place other protocols to limit contact between cohorts, as well as direct contact with parents.
- Alternate schedules with fixed cohorts of students and staff to decrease class size and promote physical distancing.

Handwashing and respiratory etiquette

Core principle for handwashing and respiratory etiquette: Through ongoing health education units and lessons, teach children proper handwashing and reinforce behaviors, and provide adequate supplies. Ensure that teachers and staff use proper handwashing and respiratory etiquette.

- **Teach and reinforce handwashing** with soap and water for at least 20 seconds and increase monitoring to ensure adherence among students, teachers, and staff. If handwashing is not possible, hand sanitizer containing at least 60% alcohol should be used.
- Encourage students and staff to cover coughs and sneezes with a tissue when not wearing a mask and immediately wash their hands after blowing their nose, coughing, or sneezing.
- Some students with disabilities might need assistance with handwashing and respiratory etiquette behaviors.
- **Adequate supplies:** Support healthy hygiene behaviors by providing adequate supplies, including soap, a way to dry hands, tissues, face masks (as feasible), and no-touch/foot-pedal trash cans. If soap and water are not readily available, schools can provide alcohol-based hand sanitizer that contains at least 60% alcohol (for staff and older children who can safely use hand sanitizer).

Cleaning and maintaining healthy facilities

Core principle for cleaning and maintaining healthy facilities: Make changes to physical spaces to maintain a healthy environment and facilities, including improving ventilation. Routinely and consistently clean high-touch surfaces (such as doorknobs and light switches).

- **Ventilation:** Improve ventilation to the extent possible to increase circulation of outdoor air, increase the delivery of clean air, and dilute potential contaminants. This can be achieved through several actions.
- Bring in as much outdoor air as possible.
- Ensure Heating, Ventilation, and Air Conditioning (HVAC) settings are maximizing ventilation.
- Filter and/or clean the air in the school by improving the level of filtration as much as possible.
- Use exhaust fans in restrooms and kitchens.
- Open windows in buses and other transportation, if doing so does not pose a safety risk. Even just cracking windows open a few inches improves air circulation.
- **Modified layouts:** Adjust physical layouts in classrooms and other settings to maximize physical space, such as by turning desks to face in the same direction.
- **Cleaning:** Regularly clean frequently touched surfaces (for example, playground equipment, door handles, sink handles, toilets, drinking fountains) within the school and on school buses at least daily or between use as much as possible.
- **Communal spaces:** Close communal use of shared spaces, such as cafeterias, if possible; otherwise, stagger use and clean between use. Consider use of larger spaces such as cafeterias, libraries, gyms for academic instruction, to maximize physical distancing.
- **Food service:** Avoid offering any self-serve food or drink options such as hot and cold food bars, salad or condiment bars, and drink stations.
- **Shared objects:** Discourage sharing items, particularly those that are difficult to clean.
- **Water systems:** Take steps to ensure that all water systems and features (for example, sink faucets, decorative fountains) are safe to use after a prolonged facility shutdown.

Communication systems

Active systems:

Self-Reporting System

Staff and families should self-report to the school if they or their student have symptoms of COVID-19, a positive test for COVID-19, or were exposed to someone with COVID-19 within the last 14 days. The reporting system should be consistent with the health information sharing regulations for COVID-19external icon (e.g. see “Notify Health Officials and Close Contacts” in the **Preparing for When Someone Gets Sick section below**) and other applicable federal and state laws and regulations relating to privacy and confidentiality,

such as the Family Educational Rights and Privacy Act (FERPA). The communication methods should be accessible for all students, faculty and staff, including those with disabilities and limited English proficiency (e.g., use interpreters and translated materials)

Notification and Update System

- Notifying staff, families, and the public of school closures and any restrictions in place to limit COVID-19 exposure (e.g., limited hours of operation).

Leave (time off) policies and excused absence policies

- As a District we will implement flexible sick leave policies and practices that enable staff to stay home when they are sick, have been exposed, or caring for someone who is sick.
  - Examine and revise policies for leave, telework, and employee compensation.
  - Leave policies should be flexible and not punish people for taking time off and should allow sick employees to stay home and away from co-workers. Leave policies should also account for employees who need to stay home with their children if there are school or childcare closures, or to care for sick family members. Additional flexibilities might include giving advances on future sick leave days and allowing employees to donate sick leave to each other, for example.
- Implement policies for individuals to return-to-school after COVID-19 illness. These policies will be informed by the CDC's criteria to discontinue home isolation and quarantine.

Reminder: All staff members must call off sick and follow the District protocol for reporting an absence. Human Resources will go over this information on an individual basis if additional assistance or explanation is needed.

Back-up staffing plan

We will monitor absenteeism of students and employees, cross-train staff, and create a roster of trained back-up staff.

Staff training

- Train staff on all safety protocols.
- Conduct training virtually or ensure that social distancing is maintained during training.

Recognize signs and symptoms

We learn more about COVID-19 every day, and as more information becomes available, CDC will continue to update and share information. As our knowledge and understanding of COVID-19 evolves, this guidance may change.
Based on the best available evidence at this time:

- **CDC does not currently recommend universal symptom screenings** (screening all students grades K-12) be conducted by schools.
- **Parents or caregivers should be strongly encouraged to monitor their children** for signs of infectious illness including COVID-19 every day.
- **Students who have symptoms of any infectious illness or symptoms consistent with COVID-19 should not attend school in-person.**
  - The profile of symptoms associated with COVID-19 remains under study and will be updated as warranted by research findings. **Further information on what symptoms may suggest infectious illness and recommended return-to-school policies is available at Screening K-12 Students for Symptoms of COVID-19: Limitations and Considerations.**
  - Schools that choose to conduct symptom screening should conduct these screenings safely and respectfully, and in accordance with any applicable privacy laws and regulations (e.g., confidentiality as required by the Americans with Disabilities Act (ADA) and the Family Educational Rights and Privacy Act [FERPA]).
  - The considerations detailed here are intended only for students in K-12 school settings. For guidance related to screening of staff, please refer to CDC's Interim Guidance for Businesses and Employers Responding to

Coronavirus Disease 2019 and the Prevent Transmission Among Employees section of CDC's Resuming Business Toolkitpdf icon.

Preparing for when someone is sick with COVID-19 (As of January 4, 2021)

Schools can prepare for when students, teachers, or staff have symptoms of COVID-19 or are diagnosed with COVID-19. In preparation for when someone gets sick we will:

Advise students, teachers, staff, and families of home isolation and quarantine criteria

Students, teachers, and staff with COVID-19 should not return to in-person school until they have met CDC's criteria to discontinue home isolation. Students, teachers, and staff who have been close contacts (within 6 feet for a cumulative total of 15 minutes or more over a period of 24 hours) of someone with COVID-19 should not return to in-person school until they have completed their quarantine.

Make sure students, teachers, staff, and families know when to stay home

Make sure that staff and families know that students, teachers, or staff with symptoms of COVID-19, with a positive test for COVID-19, or who have been in close contact with someone with COVID-19 should stay home and notify school officials (e.g., the designated COVID-19 point of contact). These critical communications should be accessible to individuals with disabilities and limited English proficiency. For detailed information on when students who have symptoms of COVID-19 can return to in-person school, visit Screening K-12 Students for Symptoms of COVID-19: Limitations and Considerations.

Isolate and transport students who develop symptoms while at school

Some students may develop symptoms of infectious illness while at school. Schools should take action to isolate students who develop these symptoms from other students and staff. Follow the school isolation protocol outlined in Screening K-12 Students for Symptoms of COVID-19: Limitations and Considerations when student develops symptoms of an infectious illness.

If someone gets sick we will: Clean and disinfect

- Close off areas used by a sick person and do not use these areas until after cleaning and disinfecting them. For outdoor areas (e.g., playgrounds, sitting areas, outdoor eating areas, etc.), this includes surfaces or shared objects in the area, if applicable.
- Wait at least 24 hours before cleaning and disinfecting. If 24 hours is not feasible, wait as long as possible. Ensure safe and correct use and storage of cleaning and disinfection productsexternal icon, including storing products securely away from children.

Notify health officials and close contacts

- In accordance with state and local laws and regulations, school administrators should notify local health officials, staff, and families immediately of any case of COVID-19 while maintaining confidentiality in accordance with the Americans with Disabilities Act (ADA)external icon and FERPAexternal icon or and other applicable laws and regulations.
- Inform those who have had close contact with a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, get tested for COVID-19, and follow CDC guidance if symptoms develop. Maintain confidentiality as required by the Americans with Disabilities Act (ADA)external icon and Family Educational Rights and Privacy Act (FERPA) or and other applicable laws and regulations.
- A school might need to implement short-term building closure procedures **if/when an infected person has been on campus** during their infectious period and has close contact with others. If this happens, **work with local public health officials to determine next steps.** One option is an initial short-term class suspension and cancellation of events and activities (e.g., assemblies, spirit nights, field trips, and sporting events) to allow time for local health officials to gain a better understanding of the COVID-19 situation and help the school determine appropriate next steps, including whether such a suspension needs to be extended to stop or slow further spread of COVID-19. In situations where schools are cohorting students (e.g., in pods) administrators may choose to close the building in places (e.g., classrooms, common areas) where others were exposed to the infected person. In the event that local health officials do not recommend building or classroom closures, thoroughly cleaning the areas where the infected person spent significant time should be considered.

- Local health officials' recommendations whether to suspend school or events and the duration such suspensions should be made on a case-by-case basis using the most up-to-date information about COVID-19 and taking into account local case-counts, and the degree of ongoing transmission in the community.

When students with disabilities or special healthcare needs gets sick:

Plan for accommodations, modifications, and assistance for children and youth with disabilities and special healthcare needs.

A customized and individualized approach for COVID-19 may be needed for children and youth with disabilities who have limited mobility; have difficulty accessing information due to visual, hearing, or other limiting factors; require close contact with direct service providers; have trouble understanding information; have difficulties with changes in routines; or have other concerns related to their disability. This approach should account for the following:

- Education should remain accessible for children in special education who have a 504 Plan or Individualized Education Program.
- Social distancing and isolating at school may be difficult for many people with disabilities.
- Wearing masks may be difficult for people with certain disabilities (e.g., visual or hearing impairments) or for those with sensory, cognitive, or behavioral issues.
- Students may require assistance or visual and verbal reminders to cover their mouth and nose with a tissue when they cough or sneeze, throw the tissue in the trash, and wash their hands afterwards.
- Where service or therapy animals are used, use guidance to protect the animal from COVID-19.
- Cleaning and disinfecting procedures may negatively affect students with sensory or respiratory issues.
- Students may require assistance or supervision washing their hands with soap and water for at least 20 seconds or using a hand sanitizer (containing at least 60% alcohol).
- Cleaning and disinfecting personal belongings, school objects, or surfaces may require assistance or supervision.
- Behavioral techniques can help all students, adjust to changes in routines and take preventive actions. These techniques may be especially beneficial for some children with disabilities and may include modeling and reinforcing desired behaviors and using picture schedules, timers, and visual cues. Organizations that support individuals with disabilities have information and resources to help schools with these behavioral techniques. In addition, behavioral therapists or local mental health or behavioral health agencies may be able to provide consultation for specific concerns.

Follow guidance for Direct Service Providers (DSPs)

Direct Service Providers (personal care attendants, direct support professionals, paraprofessionals, therapists, and others) provide a variety of home and community-based, health-related services that support individuals with disabilities. Services provided may include assistance with activities of daily living, access to health services, and more. DSPs are essential for the health and well-being of the individuals they serve.

- Ask Direct Service Providers (DSPs) before they enter school if they are experiencing any symptoms of COVID-19 or if they have been in contact with someone who has COVID-19. If DSPs provide services in other schools, ask specifically whether any of the other schools have had positive cases. For guidance related to screening of staff (to include DSPs), please refer to CDC's Interim Guidance for Businesses and Employers Responding to Coronavirus Disease 2019 and the Prevent Transmission Among Employees section of CDC's Resuming Business Toolkitpdf icon.
- If there is potential that a DSP may be splashed or sprayed by bodily fluids during their work, they should use standard precautions to avoid getting infected. They will need to wear personal protective equipment (PPE) including a facemask, eye protection, disposable gloves, and a gown.
- CDC has developed guidance for DSPs. School administrators should review the DSP guidance and ensure that DSPs needing to enter the school are aware of those preventive actions.

What to Do If You Are Sick (As of December 31, 2021)

If you have a fever, cough or other symptoms, you might have COVID-19. Most people have mild illness and are able to recover at home. If you think you may have been exposed to COVID-19, contact your healthcare provider.

- Keep track of your symptoms.
- **If you have an emergency warning sign (including trouble breathing),** get emergency medical care immediately.

Self-checker: A tool to help you make decisions and seek appropriate medical care

Get Started About the Tool

Steps to help prevent the spread of COVID-19 if you are sick

If you are sick with COVID-19 or think you might have COVID-19, follow the steps below to care for yourself and to help protect other people in your home and community.

Stay home except to get medical care

- **Stay home.** Most people with COVID-19 have mild illness and can recover at home without medical care. Do not leave your home, except to get medical care. Do not visit public areas.
    - **All staff members must call off sick and follow the District protocol for reporting an absence. Human Resources will go over this information on an individual basis if additional assistance or explanation is needed.**
    - **If your symptoms are severe or not improving beyond your isolation dates, please follow the orders of your health care professional AND you must contact Human Resources via phone or email. The policies for attendance and documentation are still in place.**
- **Take care of yourself.** Get rest and stay hydrated. Take over-the-counter medicines, such as acetaminophen, to help you feel better.
- **Stay in touch with your doctor.** Call before you get medical care. Be sure to get care if you have trouble breathing, or have any other emergency warning signs, or if you think it is an emergency.
- **Avoid public transportation**, ride-sharing, or taxis.

Separate yourself from other people

As much as possible, stay in a specific room and away from other people and pets in your home. If possible, you should use a separate bathroom. If you need to be around other people or animals in or outside of the home, wear a mask.

Tell your close contacts that they may have been exposed to COVID-19. An infected person can spread COVID-19 starting 48 hours (or 2 days) before the person has any symptoms or tests positive. By letting your close contacts know they may have been exposed to COVID-19, you are helping to protect everyone.

- Additional guidance is available for those living in close quarters and shared housing.
- See COVID-19 and Animals if you have questions about pets.
- If you are diagnosed with COVID-19, someone from the health department may call you. Answer the call to slow the spread.

Monitor your symptoms

- **Symptoms of COVID-19 include fever, cough, or other symptoms**.
- **Follow care instructions from your healthcare provider and local health department.** Your local health authorities may give instructions on checking your symptoms and reporting information.

When to seek emergency medical attention

Look for **emergency warning signs*** for COVID-19. If someone is showing any of these signs, **seek emergency medical care immediately:**

- Trouble breathing
- Persistent pain or pressure in the chest

- New confusion
- Inability to wake or stay awake
- Bluish lips or face

*This list is not all possible symptoms. Please call your medical provider for any other symptoms that are severe or concerning to you.

Call 911 or call ahead to your local emergency facility: Notify the operator that you are seeking care for someone who has or may have COVID-19.

Call ahead before visiting your doctor

- **Call ahead.** Many medical visits for routine care are being postponed or done by phone or telemedicine.
- **If you have a medical appointment that cannot be postponed, call your doctor's office,** and tell them you have or may have COVID-19. This will help the office protect themselves and other patients.

If you are sick, wear a mask over your nose and mouth

- **You should wear a mask over your nose and mouth** if you must be around other people or animals, including pets (even at home).
- You don't need to wear the mask if you are alone. If you can't put on a mask (because of trouble breathing, for example), cover your coughs and sneezes in some other way. Try to stay at least 6 feet away from other people. This will help protect the people around you.
- Masks should not be placed on young children under age 2 years, anyone who has trouble breathing, or anyone who is not able to remove the mask without help.

Note: During the COVID-19 pandemic, medical grade facemasks are reserved for healthcare workers and some first responders.

Cover your coughs and sneezes

- **Cover your mouth and nose** with a tissue when you cough or sneeze.
- **Throw away used tissues** in a lined trash can.
- **Immediately wash your hands** with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol.

Clean your hands often

- **Wash your hands** often with soap and water for at least 20 seconds. This is especially important after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- **Use hand sanitizer** if soap and water are not available. Use an alcohol-based hand sanitizer with at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.
- **Soap and water** are the best option, especially if hands are visibly dirty.
- **Avoid touching** your eyes, nose, and mouth with unwashed hands.

Avoid sharing personal household items

- **Do not share** dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people in your home.
- **Wash these items thoroughly after using them** with soap and water or put in the dishwasher.

Clean all "high-touch" surfaces everyday

- **Clean and disinfect** high-touch surfaces in your "sick room" and bathroom; wear disposable gloves. Let someone else clean and disinfect surfaces in common areas, but you should clean your bedroom and bathroom, if possible.
- **If a caregiver or other person needs to clean and disinfect** a sick person's bedroom or bathroom, they should do so on an as-needed basis. The caregiver/other person should wear a mask and disposable gloves prior to cleaning. They should wait as long as possible after the person who is sick has used the bathroom before coming in to clean and use the bathroom.

Note: High-touch surfaces include phones, remote controls, counters, tabletops, doorknobs, bathroom fixtures, toilets, keyboards, tablets, and bedside tables.

- **Clean and disinfect areas that may have blood, stool, or body fluids on them**.
- **Use household cleaners and disinfectants.** Clean the area or item with soap and water or another detergent if it is dirty. Then, use a household disinfectant.
    - Be sure to follow the instructions on the label to ensure safe and effective use of the product. Many products recommend keeping the surface wet for several minutes to ensure germs are killed. Many also recommend precautions such as wearing gloves and making sure you have good ventilation during use of the product.
    - Use a product from EPA's List N: Disinfectants for Coronavirus (COVID-19)external icon.

      Complete Disinfection Guidance

When to Quarantine

(Updated December 10, 2020)

Local public health authorities determine and establish the quarantine options for their jurisdictions. **Quarantine** is used to keep someone *who might have been exposed to COVID-19* away from others. Quarantine helps prevent spread of disease that can occur before a person knows they are sick or if they are infected with the virus without feeling symptoms. People in quarantine should stay home, separate themselves from others, monitor their health, and follow directions from their state or local health department.

Health departments: Detailed CDC recommendations for public health agencies on the duration of quarantine can be found here

What is the difference between isolation and quarantine?

Isolation and quarantine are public health practices used to protect the public by preventing exposure to people who have or may have a contagious disease.

- **Isolation** separates sick people with a contagious disease from people who are not sick.
- **Quarantine** separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms.

Stay home if you might have been exposed to COVID-19

- Quarantine is used to keep someone *who might have been exposed to COVID-19* away from others. Quarantine helps prevent spread of disease that can occur before a person knows they are sick or if they are infected with the virus without feeling symptoms. People in quarantine should stay home, separate themselves from others, monitor their health, and follow directions from their state or local health department.
- **Staying home when appropriate**: The District will educate staff and families about when they and their child(ren) should stay home and when they can return to school.

Who needs to quarantine?

People who have been in **close contact** with someone who has COVID-19—excluding people who have had COVID-19 within the past 3 months.

People who have tested positive for COVID-19 do not need to quarantine or get tested again for up to 3 months as long as they do not develop symptoms again. People who develop symptoms again within 3 months of their first bout of COVID-19 may need to be tested again if there is no other cause identified for their symptoms.

What counts as close contact?

- You were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more
- You provided care at home to someone who is sick with COVID-19
- You had direct physical contact with the person (hugged or kissed them)
- You shared eating or drinking utensils
- They sneezed, coughed, or somehow got respiratory droplets on you

Steps to take if you have had close contact with someone who has COVID-19 (excluding people who have had COVID-19 within the past 3 months).

Stay home and monitor your health

- Stay home for 14 days after your last contact with a person who has COVID-19
- Watch for fever (100.4◦F), cough, shortness of breath, or other symptoms of COVID-19
- If possible, stay away from others, especially people who are at higher risk for getting very sick from COVID-19

Options to reduce quarantine

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

Your local public health authorities make the final decisions about how long quarantine should last, based on local conditions and needs. Follow the recommendations of your local public health department if you need to quarantine.

Options they will consider include stopping quarantine

- **After day 10 without testing**
- **After day 7 after receiving a negative test result (test must occur on day 5 or later)**

After stopping quarantine, you should

- Watch for symptoms until 14 days after exposure.
- If you have symptoms, immediately self-isolate and contact your local public health authority or healthcare provider.
- Wear a mask, stay at least 6 feet from others, wash your hands, avoid crowds, and take other steps to prevent the spread of COVID-19.

Note: CDC continues to endorse quarantine for 14 days and recognizes that any quarantine shorter than 14 days balances reduced burden against a small possibility of spreading the virus. CDC will continue to evaluate new information and update recommendations as needed. See Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing for guidance on options to reduce quarantine.

Confirmed and suspected cases of reinfection of the virus that causes COVID-19

Cases of reinfection of COVID-19 have been reported but are rare. In general, reinfection means a person was infected (got sick) once, recovered, and then later became infected again. Based on what we know from similar viruses, some reinfections are expected.

Remember:

- **All staff members must call off sick and follow the District protocol for reporting an absence. Human Resources will go over this information on an individual basis if additional assistance or explanation is needed.**
- **If your symptoms are severe or not improving beyond your isolation dates, please follow the orders of your health care professional AND you must contact Human Resources via phone or email. The policies for attendance and documentation are still in place.**

Quarantine Scenarios

- **You should stay home for 14 days after your last contact with a person who has COVID-19.**
- **People with COVID-19 should be isolated for at least 10 days after symptom onset and until 24 hours after their fever subsides without the use of fever-reducing medications.**
- **For all of the following scenarios, even if you test negative for COVID-19 or feel healthy, you should stay home (quarantine) since symptoms may appear 2 to 14 days after exposure to the virus.**

Scenario 1. Close contact with someone who has COVID-19—will not have further close contact If you had close contact with someone who has COVID-19 and will not have further contact or interactions with the person while they are sick (e.g., co-worker, neighbor, or friend).	• **Your last day of quarantine is 14 days from the date you had close contact.** 

Scenario 2. Close contact with someone who has COVID-19—live with the person but can avoid further close contact If you live with someone who has COVID-19 (e.g., roommate, partner, family member), and that person has isolated by staying in a separate bedroom. I have had no close contact with the person since they isolated.	• **Your last day of quarantine is 14 days from when the person with COVID-19 began home isolation.** 
Scenario 3. Under quarantine and had additional close contact with someone who has COVID-19 I live with someone who has COVID-19 and started my 14-day quarantine period because we had close contact. What if I ended up having close contact with the person who is sick during my quarantine? What if another household member gets sick with COVID-19? Do I need to restart my quarantine?	• **Yes. You will have to restart your quarantine from the last day you had close contact with anyone in your house who has COVID-19. Any time a new household member gets sick with COVID-19 and you had close contact, you will need to restart your quarantine.** 
Scenario 4. Live with someone who has COVID-19 and cannot avoid continued close contact I live in a household where I cannot avoid close contact with the person who has COVID-19. I am providing direct care to the person who is sick, don't have a separate bedroom to isolate the person who is sick, or live in close quarters where I am unable to keep a physical distance of 6 feet.	• **You should avoid contact with others outside the home while the person is sick, and quarantine for 14 days after the person who has COVID-19 meets the criteria to end home isolation** 

When You Can be Around Others After You Had or Likely Had COVID-19

Updated Dec. 1, 2020 (CDC)

If you have or think you might have COVID-19, it is important to stay home and away from other people. Staying away from others helps stop the spread of COVID-19. **If you have an emergency warning sign (including trouble breathing),** get emergency medical care immediately. **When you can be around others (end home isolation) depends on different factors for different situations.**

Find CDC's recommendations for your situation below.

I think or know I had COVID-19, and I had symptoms.	You can be around others after: • 10 days since symptoms first appeared **and** • 24 hours with no fever without the use of fever-reducing medications **and** • Other symptoms of COVID-19 are improving* **Loss of taste and smell may persist for weeks or months after recovery and need not delay the end of isolation.* Most people do not require testing to decide when they can be around others; however, if your healthcare provider recommends testing, they will let you know when you can resume being around others based on your test results. **Note** that these recommendations **do not** apply to persons with severe COVID-19 or with severely weakened immune systems (immunocompromised). These persons should follow the guidance below for "I was severely ill with COVID-19 or have a severely weakened immune system (immunocompromised) due to a health condition or medication. When can I be around others?"

I tested positive for COVID-19 but had no symptoms.	If you continue to have no symptoms, you can be with others after 10 days have passed since you had a positive viral test for COVID-19. Most people do not require testing to decide when they can be around others; however, if your healthcare provider recommends testing, they will let you know when you can resume being around others based on your test results. If you develop symptoms after testing positive, follow the guidance above for "I think or know I had COVID-19, and I had symptoms."
I was severely ill with COVID-19 or have a severely weakened immune system (immunocompromised) due to a health condition or medication. When can I be around others?	People who are severely ill with COVID-19 might need to stay home longer than 10 days and up to 20 days after symptoms first appeared. Persons who are severely immunocompromised may require testing to determine when they can be around others. Talk to your healthcare provider for more information. If testing is available in your community, it may be recommended by your healthcare provider. Your healthcare provider will let you know if you can resume being around other people based on the results of your testing. Your doctor may work with an infectious disease expert or your local health department to determine whether testing will be necessary before you can be around others.
For Anyone Who Has Been Around a Person with COVID-19	Anyone who has had close contact with someone with COVID-19 should stay home for 14 days **after their last exposure** to that person. • The best way to protect yourself and others is to stay home for 14 days if you think you've been exposed to someone who has COVID-19. Check your local health department's website for information about options in your area to possibly shorten this quarantine period. However, anyone who has had close contact with someone with COVID-19 and who meets the following criteria does **NOT** need to stay home. • Has COVID-19 illness within the previous 3 months **and** • Has recovered **and** • Remains without COVID-19 symptoms (for example, cough, shortness of breath)

Confirmed and suspected cases of reinfection of the virus that causes COVID-19

Cases of reinfection of COVID-19 have been reported but are rare. In general, reinfection means a person was infected (got sick) once, recovered, and then later became infected again. Based on what we know from similar viruses, some reinfections are expected.

Contact Tracing

(December 16, 2020 CDC)

Case investigation and contact tracing are well-honed skills that adapt easily to new public health demands and are effective tools to slow the spread of COVID-19 in a community. Thoughtful planning can help ensure that these activities facilitate compassionate care for the people affected by COVID-19 and also prevent community transmission of the virus.

Summary of COVID-19 Specific Practices

- State and local public health officials will decide how to implement these activities and how to advise specific people, or groups of people, to be tested.
- Contact tracing will be conducted for close contacts (any individual within 6 feet of an infected person for a total of 15 minutes or more) of **laboratory-confirmed or probable COVID-19 patients.**
- Remote communications for the purposes of case investigation and contact tracing should be prioritized; in-person communication may be considered only after remote options have been exhausted.
- Testing is recommended for all close contacts of **confirmed or probable COVID-19 patients**.
- Those contacts who test positive (symptomatic or asymptomatic) should be managed as a confirmed COVID-19 case.
- Asymptomatic contacts testing negative should self-quarantine **for 14 days from their last exposure** (i.e., close encounter with confirmed or probable COVID-19 case)
- If testing is not available, **symptomatic close contacts** should self-isolate and be managed as a probable COVID-19 case.
- **Asymptomatic close contacts** who are not tested should self-quarantine and be monitored for 14 days after their last exposure, with linkage to clinical care for those who develop symptoms.
- The best way to protect yourself and others is to stay home for 14 days if you think you've been exposed to someone who has COVID-19. Check your local health department's website for information about options in your area to possibly shorten this quarantine period.

For COVID-19, a close contact is defined as: Any person who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.

** Individual exposures added together over a 24-hour period (e.g., three 5-minute exposures for a total of 15 minutes). Data are limited, making it difficult to precisely define "close contact;" however, 15 cumulative minutes of exposure at a distance of 6 feet or less can be used as an operational definition for contact investigation. Factors to consider when defining close contact include proximity (closer distance likely increases exposure risk), the duration of exposure (longer exposure time likely increases exposure risk), whether the infected individual has symptoms (the period around onset of symptoms is associated with the highest levels of viral shedding), if the infected person was likely to generate respiratory aerosols (e.g., was coughing, singing, shouting), and other environmental factors (crowding, adequacy of ventilation, whether exposure was indoors or outdoors). Because the general public has not received training on proper selection and use of respiratory PPE, such as an N95, the determination of close contact should generally be made irrespective of whether the contact was wearing respiratory PPE. At this time, differential determination of close contact for those using fabric face coverings is not recommended.*

Close Contact Evaluation and Monitoring Priorities

In jurisdictions with testing capacity, symptomatic and asymptomatic close contacts to patients with confirmed and probable COVID-19 should be evaluated and monitored.

Isolation (Positive Test)

- If any staff or student has been tested positive for COVID-19, the student or staff member should stay home and may only discontinue isolation under the following conditions:
    - At least 10 days have passed *since symptoms first appeared*; **and**
    - At least 24 hours have passed *since last fever* without the use of fever-reducing medications; **and**
    - All symptoms have improved.
- If the staff member or student has not exhibited any COVID-19 symptoms, but tested positive, their isolation may be discontinued under the following conditions:
    - At least 10 days have passed since the date of their first positive test; **and**
    - They have not subsequently developed any COVID-19 symptoms since their positive test.

Contact tracing in combination with isolation and quarantine (As of March 19, 2021)

Core principle for contact tracing: Schools should collaborate with the health department, to the extent allowable by privacy laws and other applicable laws, to confidentially provide information about people diagnosed with or exposed to COVID-19. Students, teachers, and staff with positive test results should isolate, and close contacts should quarantine. Schools should report positive cases to the health department as soon as they are informed. School officials should notify families of close contacts as soon as possible after they are notified that someone in the school has tested positive (within the same school day).

- **Staying home when appropriate:** Educate teachers, staff and families about when they and their children should stay home and when they can return to school. Students, teachers, and staff who have symptoms should stay home and be referred to their healthcare provider for testing and care.

- **Isolation** should be used to separate people diagnosed with COVID-19 from those who are not infected. Students, teachers, and staff who are in isolation should stay home and follow the direction of the local public health authority about when it is safe for them to be around others.

- **Case investigation and contact tracing:** Schools should work with the local health department to facilitate, to the extent allowable by applicable laws, systematic case investigation and contact tracing of infected students, teachers, and staff, and consistent isolation of cases and quarantine of close contacts. Schools can prepare and provide information and records to aid in the identification of potential contacts and exposure sites, consistent with applicable laws, including those related to privacy and confidentiality. Collaboration between the health department and K-12 school administration to obtain contact information of other individuals in shared rooms, class schedules, shared meals, or extracurricular activities will expedite contact tracing. For schools to remain open, health departments should ensure they have enough contact tracers to complete case investigation and notify contacts within 48 hours of a positive test

result. Prompt identification, quarantine, and monitoring of those contacts exposed to SARS-CoV-2 can effectively break the chain of transmission and prevent further spread of the virus.

  - The definition of a close contact is someone who was within 6 feet of a person diagnosed with COVID-19 for a total of 15 minutes or more over a 24 hour period. The definition of a close contact applies regardless of whether either person was wearing a mask.
  - **For schools that use less than 6 feet between students in classrooms, the definition of close contacts should not change. Students sitting less than 6 feet next to another student or person diagnosed with COVID-19 for a total of 15 minutes or more should quarantine at home and be referred for testing.**

- **Quarantine** should be used for students, teachers, and staff who might have been exposed to COVID-19. Close contacts, identified through contact tracing, should quarantine unless they are fully vaccinated, or have tested positive in the last 3 months, and do not have any symptoms. Students, teachers, and staff who are in quarantine should stay home and follow the direction of the local public health department about when it is safe for them to be around others. If a child with a disability is required to quarantine, the school is required to provide services consistent with federal disability laws.

ODH Reporting Requirements

- The staff member, student or student's parents are encouraged to alert the school district within 24 Hours. Schools must have a mechanism set up to facilitate this process, which could include any existing attendance line system, as long as it will collect the information daily.
- **Within 24 hours**, the district must notify parents of the positive(s) cases, with as much information as possible while still ensuring privacy. Four sample *Family Notification Letters* are attached for use with different audiences (3 from ODH and 1 from CCBH).
- **School districts *may* use a website dashboard to provide community updates, but are not required to do so.** The recommended information to include is the number of cases and the number of staff and students isolated or quarantined, if known.
- **Within 24 hours**, the district must also report the positive case to their local health department. Please use the attached *School-to-LHD Template*, complete the requested information in the Traditional Districts tab, and send to your local health department within 24 hours of the notification a positive test. You can include aggregate totals that occur within any 24 hour reporting period.
- The district and local health department will work collaboratively to identify to conduct a contact tracing protocol to identify any close contacts of the positive case, as defined by the CDC (within 6 feet for more than 10 minutes). For Cuyahoga County Board of Health, districts will use the attached *School Contact Tracing Line List.*

Quarantine (Close Contacts)

If any staff or student has been in close contact (as defined by the CDC) with someone who has tested positive for COVID-19, the staff or student should stay home for 14 days from their last exposure and monitor their symptoms. If they develop symptoms, they should contact a health care professional to determine next steps, which may include being tested for COVID-19. If they test positive, they should then initiate the protocol above for Isolation.

Glossary of COVID-19 Contact Tracing terms

Asymptomatic	A person who has been confirmed with the illness but is not showing symptoms. Typically, the person feels well and would not know they were ill without a test.
Symptomatic	A person who shows signs of illness such as cough, fever, runny nose, etc.
Close Contact	Someone who was within six feet of a positive person for 15 minutes or more. Also, this could be someone who was exposed multiple times within one day. Repeated short-term exposures may take place during athletic practices or other extracurricular activities.
Incubation Period	The length of time it takes for someone to show symptoms of illness after being exposed to someone or something infectious. For COVID-19, the period is 2-14 days.
Exclude/Exclusion	Exclusion occurs when someone is exposed to a symptomatic person who has not yet been tested and/or confirmed as a positive case.

Isolation	This is for people who are ill. They must be separated from others so that they do not spread their illness. It is best for the ill person to use a separate bathroom and their own set of towels, utensils and bedding. Be sure to regularly clean and disinfect commonly-touched surfaces and fixtures. Do not share food or drink with someone who is isolated.
Quarantine	This is for people who are not ill but have been exposed to someone who is. Those who are placed in quarantine need to stay home because they could become ill during their quarantine period. In either instance, they run the risk of spreading illness to others if they do not remain in quarantine. ***Even with a negative result, those placed in quarantine must remain there for the entire 14-day period.***

COVID-19: School Reporting Process

The contact tracing process includes:

- **Providing completed contact tracing line list to CCBH at schools@ccbh.net**
- Cleaning and disinfecting areas where the positive case was known to be
- Beginning a 14-day quarantine for close contacts

Reminders

- Some COVID-19 symptoms may be similar to those of allergies, cold or flu
- Be sure to check with your healthcare provider concerning medical questions
- A healthcare provider may recommend additional testing or offer a different diagnosis
- Asymptomatic cases should isolate for 10 days from their testing date
- Contact CCBH with any questions

Find a testing location or a local community health center

Visit the Ohio Department of Health's COVID-19 website at **www.coronavirus.ohio.gov**

CCBH Decision Tree

We have developed a decision tree to help school staff when dealing with COVID-19 in the school environment.

Student or staff member becomes ill

If this happens onsite, immediately isolate a student or staff member who is ill and shows symptoms. Send the person home as soon as possible.

Students and staff members who are ill must isolate at home and contact their healthcare provider.

They cannot return until they meet ALL of these requirements:

- Isolate at home for a minimum of 10 days from the date that symptoms began
- If no symptoms, isolate at home for a minimum of 10 days from the date of a positive test
- At least 24 hours without a fever and without taking medication to reduce a fever such as Motrin or Tylenol
- Symptoms improving

Identify close contacts

A close contact is defined as coming within 6 feet of another person for at least 15 minutes.

- Close contact may be cumulative, meaning repeated contact for several short periods of time qualifies someone as a close contact
- Examples of cumulative contact could include drills during athletic practices
- Extracurricular activities may need to be postponed or cancelled

Carry out cleaning and disinfecting practices

Be consistent and thorough at all times.

Notify other students and staff of cases that occur

To prepare for the return of students and staff, extraordinary precautions have been taken to minimize the risk of spreading COVID-19, including:

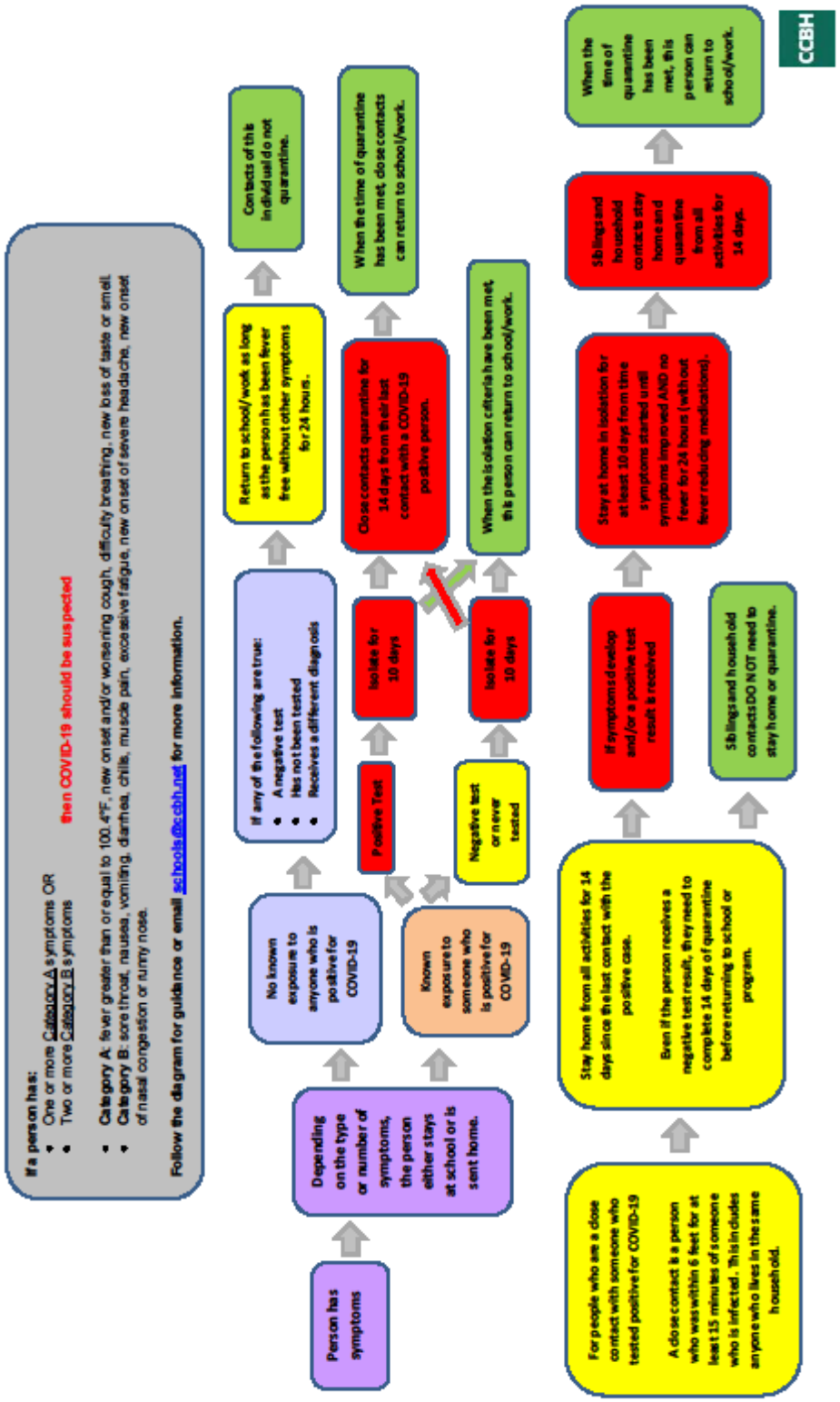
- Providing virtual/remote and hybrid options for students
- Delaying extracurricular activities and sports
- Reducing class sizes
- Increasing routine cleaning and disinfection
- Organizing seating and bus charts to identify potential contacts of reported cases
- Contact tracing for diagnosed cases of COVID-19

Families and staff can help minimize the spread of COVID-19 in schools by:

- Wearing masks
- Staying home if sick
- Practicing social distancing
- Cooperating with contact tracing efforts
- Continuing these practices when outside of school

COVID-19 Decision Tree for Schools (CCBH as of October 2020)

This Chart is intended to be used as a decision-making tool when dealing with potential or confirmed cases of COVID-19 in the school environment.



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