New York City Department of Education
Division of Early Childhood Education
Health and Safety Guidance for
NYC Early Education Centers (NYCEECs)
(as of 8/26/2020)

Please note all content in this guidance document can be amended, edited or supplemented at any time.
Introduction: Promoting Health and Safety through Trauma-Informed Care

In order to further our mission of ensuring every child has an equitable opportunity to live up to their potential, it is our responsibility to recognize and respond to the collective and individual trauma experienced by the NYC early childhood community as a result of COVID-19.

As we plan for what the 2020-2021 school year might look like for our birth-to-five programs, we must recognize that our choices can support children, families, and staff’s ability to cope with the trauma of the pandemic, but can also, if we aren’t careful, exacerbate traumatic experiences. To mitigate any possible harm or retraumatization, the Division of Early Childhood Education wants to partner with you as program leaders to have a trauma-informed approach to this pandemic.

Having a "trauma-informed approach" means that every individual in our system, regardless of title or role, will “realize the widespread impact of trauma and understand potential paths for recovery; recognize the signs and symptoms of trauma in children, families, staff, and others involved with the system; and respond by fully integrating knowledge about trauma into policies, procedures, and practices, and seek to actively resist re-traumatization.” Becoming a trauma-informed system means each of us engaging in a shift in mindset and behavior that prioritizes creating safe, nurturing, and predictable environments for everyone in our early childhood community.

Just as we strive to meet you where you are and provide as much clarity, predictability, and social-emotional awareness as possible, we aim to provide some resources and suggestions for you in order to implement the Health and Safety Guidance in this resource in a responsive way for staff and families. The Trauma Informed Care resources and suggestions in this document include:

1. Suggestions for Introducing Health and Safety Guidance to Staff and Families in a Responsive Way
2. Suggested Agenda for a Virtual Family Orientation Upon Reopening
3. Self-Care Checklist (located in Additional Resources)
4. Each section in this guidance includes a "Trauma Informed Care Consideration" that uniquely speaks to the topics covered in that section and how they can be approached in a way that prioritizes the wellbeing of your community

Overview of COVID-19 Health and Safety Requirements

This Health and Safety guidance outlines what DOE contracted programs should use to help establish measures for safety in your Article 43, Article 47 and Group Family Day Care (GFDC) centers as you reopen. There is separate Health and Safety guidance for Family Child Care Networks. This guidance is intended to align to and supplement the current New York State Interim COVID-19 Guidance for Child Care and Day Camp Programs (“NYS June 2020 guidance”), and the Centers for Disease Control and Prevention’s Guidance for Child Care Programs that Remain Open (“CDC April 2020 guidance”) which are subject to change.

Prior to reopening, all NYC early childhood programs must successfully complete all NYCDOE and licensing requirements, as well as other CDC, state, and federal requirements. These include:

- Carefully review of the DECE Fall 2020 Staffing Readiness Planning Tool, and complete the required follow-up survey (deadline was August 7; programs should complete as soon as possible)

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1 Substance Abuse and Mental Health Services Administration. SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
● Carefully review the [DECE Fall 2020 Program Readiness Checklist](#); a DECE readiness staff member will reach out to walk through this checklist with your program this summer
● Train staff in the [NYS Department of Health June 2020 guidance](#), and complete an affirmation online, and
● Complete and post the [NYS Department of Health Business Reopening Safety Plan](#).

**Many of the typical requirements for programs will remain in place, while others will need to be modified during this time.** Programs should still refer to the [3-K and Pre-K for All Policy Handbook](#). However, where expectations differ, you should adhere to this Health and Safety guidance, guidance issued by New York State, and guidance issued by DOHMH. All guidance is subject to revision and approval by City, State, and Federal regulatory and funding agencies at any time.

Supporting the **mental health and emotional well-being** of your staff, children, and families is extremely important during this time. See [here](#) for free digital mental health resources for the duration of the COVID-19 pandemic. All New Yorkers can also connect with counselors at NYC Well, a free and confidential mental health support service. NYC Well staff are available 24/7 and can provide brief counseling and referrals to care in more than 200 languages:

- Call 888-NYC-WELL (888-692-9355);
- Text "WELL" to 65173; or
- Chat online at [NYC Well](#).

We want to thank you for your continued partnership in delivering early childhood services during this challenging time, and this would not be possible without our ongoing collaboration. We value your input and feedback and want this to be an effective resource for your program during this time. If you have any questions or feedback, please contact your Policy Support Specialist or send an email to earlychildhoodpolicy@schools.nyc.gov.

**Please Note:** The Division of Early Childhood Education is working on additional resources, guidance and support for the transition back to in-person services. Some of the supports we plan to share in coming weeks include: detailed suggestions for children and staff to focus on social emotional learning and community building in the first weeks of blended learning, blended learning curricular supports, and training and resources on trauma-informed care.
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Introducing Health & Safety Guidance to Staff and Families

As we return to in-person services, programs are being asked to share health and medical knowledge and in a deeper way than ever before. Sharing health and safety guidance clearly and accurately is critical to providing safe, nurturing, and predictable environments for staff, children, and families. Adults and children feel more confident and safe when they understand what is expected of them and why. Here are some suggestions for sharing:

1. **Communicate clearly and often with staff and families about expectations.**
   - Provide written information to staff and families in their home language about the Health and Safety practices in this guidance document including:
     - What the program leadership is responsible for, what staff are responsible for, and what families are responsible for
     - Use language that is easy to understand and hard to misinterpret, avoiding medical terminology if possible
     - Be clear about what expectations are new or potentially unfamiliar to staff and families (e.g., no adult volunteers in the building, how meals are served, etc.)
   - Use visuals posted throughout the building and given as handouts for adults to reinforce expectations, including physical distancing, face covering, or meal-time expectations.
   - Provide staff and families with a point of contact to follow up with any questions or concerns regarding the Health and Safety guidance and procedures at your site.
   - Consider hosting virtual meetings for staff and families to introduce guidance and expectations upon re-opening and as things change.

2. **Provide families and children the opportunity to see and practice any new guidance that pertains to them,** some examples include:
   - **Physical Distancing:** Provide visuals showing physical distancing expectations in common areas and in classrooms, including to-scale graphics or materials (like pool noodles) showing 6 feet, as a guide.
   - **Drop off and pick up guidance:** Create a simple checklist that reminds staff and families of the drop off and pick up procedures. Consider how to model the procedures (such as daily health screens) in-person or in a short video that can be shared with staff and families.

3. **Provide families with clear information and options for completing and submitting documents** such as updated emergency contact information, current medical forms, and immunizations:
   - What is the typical timeline for these documents and how have they been extended if at all? Share a calendar or visual with families outlining the expectations.
   - What forms do they need to complete and where can they get them?
   - Can community partners help families complete these forms? Provide contact information for someone who can answer their questions about these requirements or support them in filling out the documents.

4. **Build on other practices where staff successfully attend to and communicate Health and Safety Information.** Health Literacy refers to “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” ([CDC National Action Plan to Improve Health Literacy](https://www.cdc.gov/communication/healthliteracy/national-action-plan.html)). For example, staff already use health
literate approaches with food allergies: Staff communicate with families about their needs, the dangers of, and policies related to food allergies. Staff communicate across roles about individual's needs related to food allergies, including posting food allergy information in discrete and accessible locations to ensure safety. That kind of approach can be applied to the Health and Safety Guidance for things like sanitization or classroom composition expectations, as appropriate.

- Examples of translated and age-appropriate Health Literate Information on COVID-19 from Harvard: this optional resource was developed by Harvard Health Publishing. DOE is not responsible for the content contained therein.

REQUIRED CHILD DOCUMENTATION

Trauma Informed Care Considerations:

- As families are returning to programs after an extended period of time and may have gone through individual or collective traumatic experiences, please **meet children and families where they are emotionally**.
- Please be **extra mindful** that not only might circumstances for them have changed (which may include family illness or death), but coming back to school will look completely different from when they were last in your program.

Many families will be returning to on-site services after several months and circumstances might have changed based on emergency contracts, immunizations, and family schedules. It is important that programs connect with families as soon as possible to ensure they have the appropriate documentation required to include updated emergency contact information, and proof of up-to-date immunizations, outlined below, before returning to on-site learning.

Stay-at-home orders and physical distancing practices have resulted in declines in outpatient pediatric visits and fewer vaccine doses being administered, leaving children at risk for vaccine-preventable diseases. As states develop plans for reopening, healthcare providers are being encouraged to **work with families to keep or bring children up to date with their vaccinations**.

Every child must have the following before resuming in-person learning:

- **Medical Documentation**
  - Submit a [current medical form](#) (within 12 months of the date of re-entry)
  - Proof of completed immunizations, based on the age.
    - Children must meet at least the [provisional requirements](#) (1 dose from each series) to begin on-site services, and continue to obtain vaccinations based on the “catch-up” schedule.
  - Families must give written consent for program staff to act and obtain appropriate health care in the event of an emergency.
    - If applicable, families should provide an individualized health care plan indicating specific emergency medications (i.e., an epinephrine auto-injector, asthma inhaler and/or nebulizer) to be administered for the child.
If applicable, children must have an Allergy Response Plan identifying their allergy(ies) and detailing the steps that need to be taken.

- **Contact Information**
  - Programs must confirm that they have an up-to-date Emergency Contact Card (“blue card”) for each family that includes:
    - At least 2 emergency contacts, approved escorts, home language and health related information.

### Physical Distancing Practices

**Trauma Informed Care Considerations:**

- Physical distancing looks different for young children than for adults. Children can play together in smaller groups, with a focus on washing hands and washing toys, instead of keeping children apart.
- For eating, spending time in large groups, and napping, provide visual markers for children to help them create new habits about where they should put their bodies and to offer and practice alternatives to physical contact like hugging and high-fives.
- Respond with **patience and care** when children need redirection; it is normal and expected that children want to be close to friends and caregivers.

In many programs, staff members build relationships with families by maintaining “open-door” policies and offering a variety of large-group celebrations and special events. During the pandemic, programs will need to change these practices to prevent spread of illness. Many of these expectations listed below must also be communicated to families, especially if these protocols differ from previous expectations at the program. Here are some general guidelines that must be followed:

**Adult Considerations:** Adults should maintain a physical distance of 6 feet from each other, whenever possible.

- Use strategies such as staggered schedules to avoid crowding during drop-off and pick-up routines, staff meetings, and breaks.
  - Additional guidance on strategies for drop-off and pick-up routines is in Daily Care Routines for in-person services
- Programs should reduce the number of adults onsite as much as possible, while maintaining responsiveness to the needs of children and families. Non-essential adults (e.g., delivery persons) should not be permitted indoors at the site, whenever possible.
  - Children with Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs) must receive services as recommended on their IEPs and IFSPs, either through remote, teletherapy or in-person services, depending on parents’ preference and applicable health and safety considerations. This summer and in the fall, teletherapy will continue for parents who wish to remain remote, and for families who would like in-person sessions with Special Education Itinerant Teachers (SEITs), services can be provided at childcare locations in alignment with health and safety regulations. We are currently working with our partners in DOHMH to understand how additional in-person services will work for children with IFSPs and IEPs.
  - Consider whether there are any administrative staff members who are able to work remotely while continuing to fulfill all of their responsibilities.
- Staff members must wear a face covering at all times when in the child care facility. The only exception is when they are eating or during their breaks outside of the classroom.

**Use of Facility Space:**
● If possible, designate **separate entrances and exits** into and out of the program to keep all foot traffic flowing in the same direction.

● Create **distance and directional markers**, using colored tape and/or signs, inside and outside of the program as needed to support physical distancing, especially in waiting areas such as sidewalks and hallways.

● Programs can modify the use of work areas for non-classroom staff and break spaces, so that individuals are at least six feet apart in all directions (e.g. side-to-side and when facing one another) and are not sharing work areas without cleaning and disinfection between use.

● Discourage the use of small spaces (e.g. supply closet, kitchen, or restrooms) by more than one staff member at a time, unless all staff in these spaces are wearing face coverings.

● If possible, install barriers in reception areas, security desks, and similar spaces. Barriers should be made from class A or B flame-retardant polycarbonate (light transmitting) plastics. Plexiglass should not be used as it is considered a fire hazard.

● **Open Layout Classrooms:** Some programs have open layouts where multiple classes use a single large room, separated by dividers and/or furniture. These spaces may continue to be used by multiple small, stable groups, with added precautions. Programs must ensure that traffic does not overlap within the spaces, and the staffing and child groupings are stable.
  ○ Additional non-porous barriers may be needed to prevent contact between groups of children.
  ○ Materials and supplies should not be shared between small, stable groups of children.
  ○ Air ventilation should be maximized to the greatest extent possible.
  ○ To maximize the number of children that can be accommodated on-site in small, stable groups, programs may consider converting space in the facility to serve as one or more smaller classrooms (e.g. cafeterias, gymnasiums, multipurpose rooms). Licensed child care programs should consult with their DOHMH Sanitarian prior to changing the use of space in the building, and ensure that all space used for childcare is listed on their permit.

● **Multipurpose Buildings:** Some child care programs are located in buildings that are used for multiple purposes. Child care programs should collaborate with other groups using the building to:
  ○ Ensure all groups using the facility are following shared health and safety guidelines (e.g. use of face coverings)
  ○ Limit the number of shared spaces in the building;
  ○ Minimize the number of people in the building when the child care program is open;
  ○ Determine who is responsible for cleaning and disinfection between uses of shared spaces;
  ○ Ensure that the child care program is notified if a member of a group that uses the building tests positive or develops symptoms of COVID-19;
  ○ To the extent possible, all groups using the facility should retain the name and contact information of anyone entering the facility, to enable tracking and tracing efforts by the NYC Department of Health and Mental Hygiene.
Classroom Composition

In alignment with the NYS June 2020 guidance, maximum group size and staff-to-child ratios in DOE-funded classrooms will be as follows, until further notice:

<table>
<thead>
<tr>
<th>Age</th>
<th>Minimum Staff</th>
<th>Maximum Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants (under 12 months)</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Younger Toddlers (12-24 months)</td>
<td>2</td>
<td>10 (8 for Early Head Start classes)</td>
</tr>
<tr>
<td>Older Toddlers (24-36 months)</td>
<td>2</td>
<td>12 (8 for Early Head Start classes)</td>
</tr>
<tr>
<td>Preschoolers (3- and 4-year-olds)</td>
<td>2</td>
<td>15</td>
</tr>
</tbody>
</table>

- Classrooms that are typically staffed by more than two adults may continue to be staffed this way, as long as physical distancing between adults can be maintained in the classroom space.

- **Children should stay in stable groups not to exceed the maximum number of children, as listed above.** Classrooms may reach the permitted capacity if they do not exceed the maximum group size for the specific age group. These different groups must avoid coming into contact with each other during their time on-site. For the most part, there is not an expectation that young children will maintain physical distancing within their stable groups. However, during certain activities (e.g. meals, naptime), NYS health requirements mandate more physical space between children. For example, during naptime, children should be positioned to rest 6 feet apart and head-to-toe, where possible.

- For public health reasons and to support responsive caregiving, children should have consistency in their teachers, such as a primary caregiver who is regularly assigned to the same group of children. Programs should **limit the number of classrooms** that are supported by any single staff member, including non-lead teachers.
  - For example, to cover staff breaks, ensure that the same person is providing coverage each day, and that they only provide this support for a maximum of two classrooms. Another solution to mitigate movement of adults between groups of children may be to involve a parent volunteer to support in covering breaks, when possible.
  - Staff members should take sanitary precautions, such as washing their hands and changing their personal protective equipment (including face covering and smock) any time they are transitioning between different groups of children.
  - If children typically receive instruction from enrichment teachers who support multiple classes with activities such as art, music, yoga etc., consider if that instruction can be delivered by the primary teaching staff, or as part of your program’s remote learning plan.

- There should be separate gross motor play time allotted for all age groups (infants, toddlers, and preschoolers) and classrooms, while also ensuring that physical distancing is maintained to the greatest extent possible.
● Outdoor areas generally require normal routine cleaning and do not require disinfection. Spraying disinfectant on outdoor playgrounds is not an efficient use of disinfectant supplies and has not been proven to reduce the risk of COVID-19 to the public.
  ○ Existing cleaning and hygiene practices should be maintained for outdoor areas. If practical, high touch surfaces made of plastic or metal, such as grab bars and railings, should be cleaned routinely. Cleaning and disinfection of wooden surfaces (e.g., play structures, benches, tables) or groundcovers (e.g., mulch, sand) is not recommended.

Off-Site Space Usage

● Programs are not prohibited from using off-site spaces (e.g., playgrounds, parks, open green spaces) for gross motor activities.
● Programs must have appropriate written permission from families prior to taking children off-site.
● Staff and children over the age of 2 must wear face coverings when travelling from program and while at off site space
● Programs must have hand sanitizer readily available for use while off-site
● Programs must ensure that children and staff are not mixing with other groups of children or adults while at off-site spaces.
● Programs must be able to demonstrate they are meeting all health code regulations relating to going off-site, as well any additional city, state, and federal guidance pertaining to COVID-19.

DAILY CARE ROUTINES FOR IN-PERSON SERVICES

Trauma Informed Care Considerations:

● Most children and staff have not been in a program for several months and therefore are no longer familiar with the normal routines that they experienced previously. Therefore, it is important to consider each child’s transition needs by setting routines and schedules that are responsive to children’s needs, so children will experience a safe, nurturing and predictable environment. It is equally important to re-familiarize staff with routines and update them where there have been changes.

Transitioning Back to Program for Children and Families and Staff

Virtual Family Orientation upon Reopening
As we welcome families back to in-person services, having a Family Orientation continues to be a best practice for providing a responsive environment for families and their children. While these events should happen virtually, not in person, it is important to ensure that families are informed and feel comfortable leaving their children at your program at a time when there is a great deal of anxiety related to COVID-19. Programs should emphasize the priority on Social-Emotional Wellbeing and Family Partnerships, while sharing any changes to the new health and safety expectations to include physical distancing, groupings of the children, daily hygiene practices and action plans as it relates to emergencies such as COVID-19 positive cases.
Please see here for a suggested agenda for this orientation.

**Staff Orientation upon Reopening**
It is equally important to ensure that all staff, those returning to on-site services and those continuing to work remotely, gather for an opportunity to learn of all new updated practices and procedures and have the opportunity to ask questions. This event can be conducted virtually; however, if conducted in person physical distancing measures must be put in place and all staff must wear face coverings.

**Daily Health Screens for Children and Staff**

<table>
<thead>
<tr>
<th>Trauma Informed Care Considerations:</th>
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<tbody>
<tr>
<td>● Daily health screens and new and intensified hygiene routines will be new procedures for most children and families. Helping everyone know what to expect prior to re-opening will help everyone to be at ease.</td>
</tr>
<tr>
<td>● For health screens, prepare staff to ask for permission from children and to <strong>narrate procedures</strong> as they occur: “We are keeping everyone healthy by checking on our temperatures- how warm your body is. Can I point this thermometer at your head? It won’t hurt and will only take a second.” You might <strong>add thermometers and checklists to your dramatic play area</strong> to help children acclimate to seeing and using these materials at school.</td>
</tr>
</tbody>
</table>

Daily health screens should be conducted for both children and staff before arriving at the program, or upon arrival. Program leaders must instruct program staff members to **stay home if they are sick** and remind family members to keep sick children home.

Programs must identify a **site safety monitor to oversee daily staff and child health screens** and track all people entering the facility. Child health screens must be completed and documented either prior to arrival, or before families leave the program in the morning. Staff screens should also be documented and completed prior to arrival or upon staff’s arrival for their shift. Consider using this resource to document the **individual child health screens**. Please reference **DOHMH Sample COVID-19 Symptom Screening Tool** for additional guidance on **staff health screens**. Daily health screen logs should be maintained for the duration of the public health crisis. In programs that have existing nursing staff, nurses may be best qualified to fulfill this role, but this role can also be combined with other staff duties.

**Upon Entry:**

● Children and staff must be healthy in order to attend the program.

● Staff and family members should look out for signs and symptoms of COVID-19 in themselves and children. Staff and family members must notify you if they/their children test positive for COVID-19, are identified as a close contact of someone who has COVID-19, or develop symptoms of COVID-19, at any time including outside program operating hours.
○ Staff should make a visual inspection of a child for signs of illness, which could include flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness, and confirm that the child is not experiencing coughing or shortness of breath.

● At a minimum, daily health screenings must be completed prior to entering the program using a questionnaire that determines whether each individual has:
  ○ Been knowingly in close or proximate contact in the past 14 days with anyone who has tested positive through a diagnostic test for COVID-19 or who has or had symptoms of COVID-19;
  ○ Tested positive through a diagnostic test for COVID-19 in the past 10 days;
  ○ Experienced any symptoms of COVID-19, including a temperature of greater than 100.0°F, in the past 10 days; and/or
  ○ Traveled (or has a visitor who is staying in the home with them) internationally or from a state with widespread community transmission of COVID-19 per the New York State Travel Advisory in the past 14 days.
  ○ Received a directive from DOHMH or NYC Test and Trace Corps to quarantine.

● As part of the daily health screenings, programs must perform random temperature checks for both children and program staff using non-contact thermometers (such as an infrared forehead thermometer or infrared scanner), and following protocols in the CDC April 2020 guidance.
  ○ The person using the non-contact thermometer should strictly follow the manufacturer’s instructions for use. Additional guidance regarding use of non-contact infrared thermometers can be found here or at fda.gov (search for “non-contact thermometer”).
  ○ When non-contact thermometers are used and the screener does not have physical contact with the screened individual, gloves do not need to be changed before the next check. However, the thermometer should be cleaned with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual. You can reuse the same wipe as long as it remains wet.

● In addition to the random temperature checks on-site, programs may either:
  ○ Request program staff and family members take their own or their child’s temperature each day and report the results to the program before arriving in person at the facility, or
  ○ Designate a staff member to take the temperature of all persons entering the facility using a non-contact thermometer.
  ○ Any individual that has a fever of 100 degrees or above should not be admitted to the facility.

● Health screenings should be conducted in a location that is not a confined space (for example, do not use a small office with a closed door). If possible, perform screenings outdoors.

● Staff, children, family members, and any other person who enters the program must maintain at least six feet of distance from others while awaiting health screenings.

● Screeners and individuals being screened (except for children two years of age and under) must wear face coverings if they can medically tolerate them.

● Programs should design a way to screen that prevents others from hearing what is being said and to minimize others from observing screenings. Additionally, wherever possible, programs should incorporate physical distancing (maintaining at least six feet between screeners and others), or physical barriers, to minimize the screener’s and the screened individual’s exposure during the screening.

● If any child (or staff member who supervises on the bus) is transported via school bus, the daily health screens should be completed prior to boarding the vehicle.
  ○ Children should board buses and be seated at first from the back of the bus to the front of the bus to eliminate crossing seated individuals.
  ○ When disembarking, children in the front should get off the bus first to eliminate crossing seated individuals.
When documenting information related to health screens, programs are prohibited from keeping records of employee data (e.g. the specific temperature data of an individual), but are permitted to maintain records that confirm individuals were screened and the result of such screening (e.g. pass/fail, cleared/not cleared).

Any program staff or child exhibiting symptoms of COVID-19, or with a household member exhibiting symptoms of COVID-19, must not be allowed to enter the program. Symptoms may include:
- Fever of 100.0°F or higher or chills,
- Cough, shortness of breath or difficulty breathing,
- Fatigue,
- Muscle or body aches,
- Headache,
- Loss of taste or smell,
- Sore throat, congestion or runny nose,
- Nausea or vomiting,
- Diarrhea.

Family Members Who Have COVID-19 or Symptoms of COVID-19

- In the event that a family member of a child must be isolated because they have tested positive for, or exhibited symptoms of, COVID-19, the family member must be advised that they cannot enter the program for any reason.
- If the family member – who is a member of the same household as the child – is exhibiting signs of COVID-19 or has been tested and is positive for the virus, utilize an emergency contact authorized by the parent to come pick up the child. As a close contact, the child must not return to the program for the duration of the quarantine.
- If the parent/guardian – who is a member of the same household as the child – is being quarantined as a precautionary measure, without symptoms of the virus or a positive test result, staff should escort the child to the parent/guardian at the boundary of, or outside, the premises. As a “contact of a contact,” the child may return to the program during the duration of the quarantine.

Quarantine Requirements for Out-of-State Travel

- Per State guidance, all travelers entering New York who have recently traveled within a state with either a positive test rate higher than 10 per 100,000 residents over a seven-day rolling average, or a testing positivity rate of higher than a 10% over a seven-day rolling average, are required to quarantine for a period of 14 days. The requirements of the travel advisory do not apply to any individual passing through designated states for a limited duration (i.e., less than 24 hours) through the course of travel.
- The designated states with significant community spread will be conspicuously posted on the State DOH website and will be updated weekly. Programs should check the website frequently as the information will change as often as daily, as rates of COVID-19 transmission increase or decrease.

Drop Off and Pick Up Routines
Trauma Informed Care Considerations:

- Dropping children off in a more public-facing environment might produce stress or anxiety for families.
- Be clear about what the pick up and drop off expectations are and why they are there.
- For example, let them know that families are not allowed in the classroom for safety and health reasons, but that they will be watched and cared for as they transition to the classroom.
- Create a simple checklist that reminds staff and families of the drop off and pick up procedures. Consider how to model the procedures (such as daily health checks) in-person or in a short video that can be shared with staff and families.
- Let families know about how teachers and the program will stay in communication with them throughout the day, week, and in case of emergency.

Following the health screen, children should be dropped off (and picked up) at the front of the building (or designated entrance) and escorted to their classroom program by a staff member. This is to limit the number of adults accessing the building to prevent the spread of illness.

- **At the start of the program year:** At the beginning of the program year, it is important to build trust by allowing family members to enter the building and their child’s classroom with their child. To do this safely, consider strategies such as:
  - Offering individual and/or virtual tours of the building before the program begins;
  - Shortening program days and staggering arrivals at the beginning of the year, so that if a family needs to accompany their child into the building, there will be fewer people in the hallways
- After an initial period, once children are more comfortable, programs are encouraged to implement protocols so that drop-off and pick-up routines take place at the front of the building, so that most family members do not enter the facility. These routines should remain flexible and responsive to the emotional needs of each child and family.
  - If family members do enter the program, they must have a health screening, must wear a face covering, must wash their hands or apply an alcohol based hand sanitizer that contains at least 60% ethanol (upon entry and may not stay for an extended period) and maintain 6 feet of physical distancing between other adults.
- Consider staggering arrival and dismissal times, especially in larger programs, in order to avoid a large group of families congregating in or near the program.
  - Physical distancing precautions (e.g. distance markers) should be in place so that family members and children waiting to enter the site do not come into close contact.
- Programs continue to be responsible for maintaining sign-in/sign-out records. Consider incorporating a sign-in procedure into your health check process at the building entrance.
- Once children are in the building, they should be taken to wash their hands immediately before beginning program activities.

**Throughout the Day:**

- Program staff and families must notify the program immediately if they become aware that any of the responses to the daily health screening questions answered before arrival have changed.
- Program staff must make visual inspections of children for signs of potential COVID-19 illness which could include flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness.
- Pay special attention to children with chronic medical conditions, as they can be at higher risk for poor outcomes of COVID-19.
● These additional checks can be incorporated into daily routines such as before a meal, after a nap, during toileting, etc. These inspections do not need to include a temperature check or be documented.

**Daily Hygiene**

**Trauma Informed Care Considerations:**

● When families forget to return washed bedding or forget to complete another of their health and safety responsibilities, kindly remind them that their child is missing a key item well in advance of them needing it (i.e. in the morning long before naptime) and follow up as needed. If your program can, consider keeping clean bedsheets available in case of an emergency.

● Remember general best practices for handwashing, take time to introduce why and how children should wash their hands in fun and engaging ways. For example, you might mix a little cinnamon with lotion and tell children it will show them the invisible germs on their hands. Have them wash off the mixture while singing a song that helps them wash for the needed 30 seconds.

● With more frequent handwashing, there may be more time spent waiting in line. Consider ways to make waiting fun and engaging for children. Consider different songs, hand games, or other activities where children can safely move their bodies and play while waiting for their turn to wash. An adult should facilitate these activities and assist children in taking turns.

● Programs will be expected to ensure there are protocols in place for increased handwashing while using the appropriate procedure throughout the day and enough time to do so.

● Programs should continue to support children who are still working towards full mastery of toileting skills.

● Programs will be expected to ensure that children’s bedding (blankets and sheets) are cleaned weekly or more frequently as needed.
  ○ All children’s bedding materials should be stored separately and not touching.

● Individuals should cover mouths and noses with a tissue or sleeve when sneezing or coughing. Do not use hands.

● Programs must post signage throughout the site that reminds staff members to:
  ○ Cover mouth and nose with a face covering.
  ○ Properly store and, when necessary, discard PPE.
  ○ Adhere to physical distancing instructions.
  ○ Report symptoms of or exposure to COVID-19, and how they should do so.
  ○ Follow hand hygiene and cleaning and disinfection guidelines.
  ○ Follow appropriate respiratory hygiene and cough etiquette.

● Post the [NYC DOHMH hand washing protocol](#) and OCFS’s “STOP THE SPREAD” poster.

**Hand Hygiene**

Handwashing or hand sanitizing must take place for all children and program staff:

● Upon arrival to the building and classroom and after breaks

● Upon arrival to the first program activity

● Before departing the last program activity

● Between all program activities

● Before and after administering medication or medical ointment

● After coming in contact with bodily fluid

● Before and after diapering

● After using the restroom and supporting children with toileting
After handling animals or cleaning up animal waste
After playing outdoors or in sand
After handling garbage
Before and after preparing food or drinks
Before and after eating
Any time after touching the eyes, nose, or mouth, or any time a bodily fluid may be on the hands
Any time after touching a frequently touched/shared surface

Handwashing is preferred to hand sanitizer, and handwashing is required whenever hands are visibly soiled. Hand sanitizer is encouraged as an alternative if a handwashing station is not readily available. Hand sanitizer must be alcohol-based and contain at least 60% ethanol for areas where handwashing facilities are not available or practical. Hand sanitizer should be available throughout common areas such as entrances, exits, outdoor spaces and security/reception areas. Young children should always be supervised when using hand sanitizer to prevent an accidental swallowing of the product.

To facilitate hand hygiene practices and minimize wait time for children, programs are strongly encouraged to add portable handwashing stations to any classroom that does not currently have a sink.

Toothbrushing

Promoting good oral health and the prevention of tooth decay is of importance for all young children. However, to reduce the risk of COVID-19, it is recommended that tooth brushing be suspended in the programs until it is considered safe again. Programs should continue to encourage families to brush their children’s teeth with fluoride toothpaste before they come to the program and before bedtime. The program can also share resources about tooth brushing with their families.

Personal Protective Equipment

Trauma Informed Care Considerations:

- Having caregivers in masks and other protective equipment will be a new experience for many young children. Children will need to be introduced to mask-wearing the same way they are introduced to other expectations and routines in the classroom-- through repetition, playfulness, and practice.

- Families will have different needs and practices about mask-wearing for their children. Please do your best to understand the needs and preferences of each family and work with them to best maintain a healthy environment for everyone in your program. Create games and activities around wearing masks, including allowing children to try out their own masks if they want to. Consider encouraging families to leave extra masks in their child’s cubby in case they forget theirs one day. For more information on face coverings, see this guidance created for ECCs and FCC-ECCs over the summer.

- It is important to comfort crying, sad, and/or anxious infants and toddlers, and they often will need to be held.

Face Coverings
In alignment with current Executive Orders and in response to new information about Multisystem Inflammatory Syndrome in Children (MIS-C), all staff (and any other adults) must use a face covering while they are on-site at programs.

Face coverings should not be used by children 2 years of age or younger, or by anyone who cannot medically tolerate one. If programs take children off the child care premises (e.g. on neighborhood walks), children must wear face coverings. Additional information regarding children’s use of face coverings is forthcoming.

Additional Health and Safety Guidelines for Use of Face Coverings

- A face covering can include anything that covers your nose and mouth, including homemade cloth face coverings. Medical-grade PPE (e.g., N-95 respirators) remain a critical need for health care workers and first responders and, therefore, should be prioritized for those settings. Where possible, programs and staff can consider utilizing clear masks but this is not required.
- Programs must make face coverings available to staff at no cost. Reusable face coverings/masks are strongly encouraged as they are best for the environment and most sustainable over time.
- Face coverings should be used while traveling to and from a program (except for children under the age of 2), if social distancing cannot be maintained, such as on public transportation.
- All family members or other adults (e.g., delivery personnel, etc.) who need to enter a program must be wearing a face covering. Programs are encouraged to keep a supply of additional face coverings onsite for distribution to anyone who needs one in order to enter the program.
  - When entering a program with a face covering used outdoors, it is recommended that staff switch to a clean, uncontaminated face covering/mask.
  - It is a best practice for staff to have at least two separate face coverings: one for commuting to the site and one to wear on-site. Face coverings must also be changed any time a staff member switches to work with a different group of children.
- Face coverings should be stored in an airtight container (such as a plastic sandwich bag with a zip) and labeled with the individual’s name.
- Gloves and proper sanitation should always be used when touching a used or contaminated face covering/mask.
- When putting on and taking off a face covering, wash your hands for at least 20 seconds with soap and water or, if not available, use an alcohol-based hand sanitizer that contains at least 60% ethanol every time you put on and take off your face covering. If you are unable to clean your hands, be very careful not to touch your eyes, nose or mouth when putting on and taking off your face covering.
- Face shields are not an alternative to face coverings or masks. Face shields can be worn with face coverings, but alone do not adequately cover an individual's nose and mouth, which is needed to mitigate the spread of the virus.

Reusable face coverings need to be washed using detergent between each use. Face coverings should be fully dry before using again.

Considerations for Children Who Wear Face Coverings

- Moisture buildup is a real concern with face covering wearing for young children; therefore, the following procedures/guidelines should be put in place:
  - Conduct frequent checks for moisture build-up and/or the development of facial rashes on any children who are wearing face coverings/masks. Consider incorporating rash checks during bathroom schedules and meal times.
Any signs or symptoms of a rash should be documented and families should be notified according to DOHMH protocol.

- Please be mindful of younger children with face coverings if they are around small items that could be choking hazards.
- Engage families in ongoing communication as to how people wearing face coverings may be impacting their child(ren).

**Communicating with Children While Wearing Face Coverings**

- Children rely on our body language and expressive tones to interpret adult messages. When staff are wearing face coverings, children will not be able to see their facial expressions, so eye contact and voice inflection are especially important.
- Children and adults rely on lip reading and facial expressions to understand each other’s language; therefore, it is imperative that adults speak clearly. Staff should be sensitive and patient as children adapt to social interactions and work to understand language with adults who are wearing face coverings.
- In the classroom, share photos of real adults and children wearing face coverings. Help children understand that face coverings help to keep us safe and keep away from germs.
- Consider hanging photos of children’s and staff members’ faces without face coverings around the classroom, and having staff pin photos of themselves without face coverings to their shirts so that children can see their smiling faces.

**Meeting Children’s Social Emotional Needs While Wearing Face Coverings**

- Some children may find face coverings scary. It is important that adults remain attuned to how children are feeling and provide a lot of comfort, positive reinforcement and space for children to express their feelings.
- Children play out their feelings and experiences. Encourage children to draw and use dramatic play materials to express their thoughts, feelings, questions and concerns.
- Be mindful of children who are sensory-sensitive or struggle with change. Be patient and responsive to their needs.

**Other Considerations**

- Program staff are encouraged to wear a **smock or oversized button-down shirt** while working with children, which should be changed after use or any time it becomes contaminated. Program staff are also encouraged to wear long hair in a ponytail or other updo.
- Program staff should wear **gloves** during health screening, meal times, when supporting children with toileting, and during any other activities when in close contact with children or any frequently touched surfaces. When used, gloves should be changed:
  - If coming into contact with another person (e.g. when supporting a child during toileting, as needed during daily health checks or meal times), change gloves in between contacts with another person;
  - Before transitioning to the next activity (e.g. after wiping down toys or tables, after plating meals for children, etc).
- Whenever a child’s clothing becomes dirty with bodily fluids (including drool), change the child’s clothing, and as necessary, clean the child (e.g. wash hands or arms).
Children should have multiple changes of clothes on hand at the program. Programs should make efforts to have spare changes of clothes for children who either do not have extra clothes or have used their extra clothes, as practicable.

- For programs with infants that are bottle fed, program staff should wash their hands before and after handling bottles prepared at home or prepared at the program.
  - Bottles, bottle caps, nipples, and other equipment used for bottle-feeding should be thoroughly cleaned after each use by washing in a dishwasher with a bottlebrush, soap, and water.
  - If your program does not have that capability, consider asking families to provide enough bottles for the number of feedings per day and send home the used bottles to be properly cleaned.

MEALS

Trauma Informed Care Considerations:

- Meal time is an opportunity to build a family-like atmosphere through conversation and relationship building. Even though family-style meals are not possible at this time, you can still use meal time to foster conversation and connection between children, adults, and peers.

Meals are an important component of every early childhood program. This is a time that allows children and staff to engage in conversations and learn valuable skills. This is also a part of the program that many families depend on to ensure their children have nutritious and well-balanced meals and snacks daily.

On-site Meals

Programs are expected to provide the required number of meals to their children according to their contract. In EarlyLearn programs that is two meals and a snack and in 3K and PreK programs that is, at a minimum, a meal and a snack or two meals. Programs are required to provide all meals and snacks in the classroom and temporarily the meals cannot be served family style. Children should not be serving themselves any food or pouring any drinks to avoid any spreading of germs. Programs should make the seating arrangements during meals to provide as much space between individuals as possible, while still ensuring that staff can engage in conversations with the children and provide adequate supervision. Additionally, children and staff should be reminded of the importance of not sharing food during this time.

Any children who wear face coverings while at child care programs should remove them during meals and store them appropriately.

Children receiving remote learning (Child and Adult Care Food Program (CACFP) participants only)

Under normal circumstances, CACFP requires that participants eat together (congregate feeding) on site. Recently, the United States Department of Agriculture (USDA) granted a nationwide waiver for non-congregate feeding, which allows CACFP Sponsors to continue serving meals to children participants at your programs. Since we know that all families may not feel comfortable to return to programs for in-person learning at this time, you may want to apply for this option to ensure your enrolled children can continue to receive nutritious and well-balanced meals and snacks daily, even when they are not on-site.
As a CACFP-participating child care center, if you would like to use this option to continue feeding your regularly enrolled children, please complete this [application] by following this [guidance] with information about options, how to obtain approval, general requirements for non-congregate feeding, and logistical considerations.

Programs must offer children breakfast, lunch, and an afternoon snack using the USDA/CACFP nutrition guidelines. Programs should continue to pay for food expenses using CACFP funds and submit invoices for reimbursement under normal protocols.

For sites that do not participate in CACFP, more information is forthcoming about meals for children during remote learning days.

**STAFF QUALIFICATIONS**

**Trauma Informed Care Considerations:**

- In addition to ensuring hired staff have the appropriate qualifications for their positions, programs should also ensure that staff hired show a high level of social emotional responsiveness to children’s needs.

- Submitting documentation may be hard for staff in their current personal and professional circumstances. If staff need to submit documentation, let them know verbally and in writing so they know exactly what forms are needed, when they should be submitted, and where/to whom they should be given.

Programs should plan to continue to employ all staff currently on their DOE budgets, but you may need to make adjustments to your current staffing plan in order to provide accommodations for certain staff. All program staff must meet the applicable laws and regulations specific to their titles (e.g. group teacher, assistant teacher).

At a minimum, programs should have on-site the following staffing:

- **Program/education director**
- Two (2) **teaching staff** in each in-person classroom; programs are strongly urged to designate and train one certified lead teacher to act as the designee for the education director when s/he is offsite

- **Administrative support** to meet food service and security needs (some clerical and/or fiscal staff may be able to work partially or fully remotely)

- **Custodial support** to clean the program thoroughly at least once per day (ideally, scheduled to be available throughout the program day)

- Staff member who holds **certificate of fitness** available during all hours of operation

- At least one individual who is trained in **First Aid & CPR**

- At least one individual who is trained to administer an epinephrine auto injector

- At least one person certified in food handling must be onsite during all food service

- If available, **family support worker**

- Programs must develop a substitute staffing plan that accounts for absences for all essential onsite staff.
Additional information on staffing expectations for remote learning is being developed and will be released shortly.

**Staff Documentation**

- All program staff must share a primary contact number and two emergency contact phone numbers.
- Programs must have documentation on site ensuring appropriate security clearances for all program staff.
  - All staff must be added to your program’s PETS roster and be eligible (including if they were fingerprinted and cleared through DOI or IdentoGO); and
  - All newly hired staff (after September 25th, 2019) must be fingerprinted and cleared through PETS in order to begin working and have completed the Comprehensive Background Clearance (CBC). The program must be able to provide proof of such clearance (e.g. appears eligible in PETS and has a CBC approval letter).

**Emergency COVID-19 Teaching Certificate**

Many candidates may have been unable to take required exams to complete requirements for teaching certificates during COVID-19. To support these candidates and the education workforce, New York State Education Department (NYSED) has authorized an emergency certificate that would allow a candidate to be certified for a one-year period while taking and passing the required exam(s) for the certificate sought (e.g. Initial certification).

*Who would be eligible?*

Candidates who have completed all requirements for the certificate sought, other than the exam requirement(s), on or before **September 1, 2020**, may apply for the one-year Emergency COVID-19 certificate. The certificate is valid for one year; during this time, the candidate must meet exam requirements to avoid any lapse in certification status. If the candidate meets all exam requirements by the end of the one-year Emergency COVID-19 certificate, they will be eligible to transition to a new certification (e.g. Initial certification).

For more information about this certificate and application process, please visit NYSED’s website [here](#). For further clarification and/or support in this application process, please reach out to the Early Childhood Policy Team at [earlychildhoodpolicy@schools.nyc.gov](mailto:earlychildhoodpolicy@schools.nyc.gov).
### SAFETY PLAN GUIDANCE

**Trauma Informed Care Considerations:**

- Reinforce for families that the program is prepared to care for their children and keep them safe, even in an emergency. Explain to families that it is very important for families to update all blue card information for emergency contacts and for authorization of the person to pick the child up from school due to an emergency.

- With so many emotional and health needs to juggle, revisiting emergency plans with staff can provide structure and a reassurance that they will know what to do in case of an emergency. As you train staff in new health and safety expectations, also revisit and practice emergency safety plans to ensure everyone feels knowledgeable about what to do in moments of crisis.

There must be written policies and procedures in place related to the safety of staff and children, circulated to all staff on the premises on how the health and medical requirements of the NYC Health Code are implemented.

All programs must prepare a [NYS Business Reopening Safety Plan](#) and post it where it can be easily seen and read. This is in addition to your existing safety plan as an Article 43, Article 47 or group family day care provider. **Please ensure both safety plans are up-to-date and accurately reflect protocols and staff currently within your program.**

Programs should provide in-depth staff training on all safety plans and emergency plans before resuming onsite services.

### HEALTH GUIDANCE

**Trauma Informed Care Considerations:**

- Being sick in this moment can create a lot of stigma and generate fear. When a child is showing symptoms of illness or a family is experiencing illness, please maintain confidentiality among non-involved parties (e.g., families of other children, children in the classroom). If families do need to quarantine, ensure staff are aware of the protocol, including that when it is time for the child to re-enter the program they should be warmly welcomed and included in daily activities.

- Consider how you can reduce fear around the isolation space. This might include adding child-friendly materials. In small groups, show children where the isolation space is and explain that it is a safe place to go when someone does not feel well and is waiting for help from their family or doctor to feel better. Explain to children what happens in the isolation space. Reinforce the same ideas for staff, this is a safe place to come while their colleagues get them help and/or care.

The situation regarding COVID-19 is rapidly changing, as is our knowledge of this new disease. The guidance below is based on the best information currently available. This guidance for DOE-contracted early childhood
programs is intended to supplement all relevant city, state and federal law and guidance, including guidance issued by New York State and the NYC Department of Health and Mental Hygiene (DOHMH).

COVID-19 Testing
Programs should ask all staff to be tested for COVID-19 at least seven days prior to the start of in-person services, including staff members working in any classrooms not contracted by the DOE. Participation in COVID-19 testing for program staff is entirely voluntary. Program staff members should also be encouraged to opt into monthly repeat surveillance COVID-19 testing. Testing may occur at any location, but staff are encouraged to use City-run testing sites.

Isolation Space
Your program must have a private area (such as an enclosed room, but at a minimum a cot in a private area) provided for separating symptomatic children under direct adult supervision until a family member can pick up the child, or symptomatic staff members until they can safely leave the facility.

- Programs must maintain a supply of medical and emergency equipment and supplies in the designated isolation space, including go bags/kits and appropriate personal protective equipment (PPE), including, but not limited to N95 respirators, gloves, gowns, and face shields or goggles.

Symptomatic Children and Staff
- All program staff must be familiarized with the symptoms of COVID-19. These symptoms may include:
  - Fever or chills,
  - Cough, shortness of breath or difficulty breathing,
  - Fatigue,
  - Muscle or body aches,
  - Headache,
  - Loss of taste or smell,
  - Sore throat, congestion or runny nose,
  - Nausea or vomiting,
  - Diarrhea.

- If a child is showing any symptoms of COVID-19, program staff should:
  - Escort the child to the isolation space while wearing appropriate PPE.
  - Nurse should assess if the child is in acute respiratory distress for 911 activation:
    - If the program does not have an on-site nurse, the identified site safety monitor should do this assessment. Programs may consult the nursing triage hotline if needed (more details to come).
    - If 911 is called, complete and submit a DECE Occurrence Report.
  - If the child is stable enough, notify the child’s parent/guardian to come and pick up the child. Strongly advise the family to visit a doctor and get the student tested for COVID-19, and provide the information of the closest testing site, if asked.
  - Upon completing the supervision of the child (transferring custody to the parent/guardian), the staff member should remove gloves (taking care to touch only the inner surface of the glove) and wash hands. Then remove the following in this order taking care to touch only the back of the items: face covering, smock, then wash hands. Hands should be washed after removing each item. All items should be disposed of in a regular garbage bin, or washed for reuse, as appropriate.

- If a staff member is symptomatic upon arrival at work or becomes sick with COVID-19 symptoms while at work, the staff member must be separated and sent home immediately. If the employee does not feel
well enough to leave on their own, the program leader should assist with arrangement of ambulance services, if appropriate, or other safe transportation home, such as calling a family member to accompany the staff member home. If 911 is called, complete and submit a DECE Occurrence Report. Any adults waiting with the employee should stay at least six feet away from the employee in the designated isolation space. Strongly advise the staff member to visit a doctor and get tested for COVID-19, and provide the information of the closest testing site, if asked.

- Immediately close off areas used by any person with COVID-19 symptoms.
  - Thoroughly clean and disinfect any affected areas according to the CDC guidance on Cleaning and Disinfecting Your Facility.
  - Open outside doors and windows to increase air circulation in the affected areas, to the extent practicable while maintaining all health and safety standards.
  - Wait 24 hours before you clean and disinfect the affected areas. If 24 hours is not feasible, wait as long as possible (at least 2 hours).
  - Clean and disinfect all areas used by the person with COVID-19 symptoms, such as the isolation space, bathrooms, common areas, and shared equipment.
  - After cleaning and disinfecting the affected areas, these areas can be used for other purposes.

- If a child or staff member is exhibiting COVID-19 symptoms, but there is no laboratory-confirmed positive test result, there is no requirement to close the classroom or program building.

- If the symptomatic individual gets tested, the person must stay home while waiting for their test results for at least 10 days and cannot attend the program (or any other child care program).
  - If a positive case is confirmed, programs must follow the protocols in the next section.
  - If a negative laboratory-confirmed test result is received, the individual may return to the program if they have been fever-free for 24 hours without the use of fever-reducing medication AND their overall illness has improved.

- If the symptomatic individual does not get tested, then the individual cannot return to the program until:
  - 10 days have passed since the first symptom; AND
  - The individual has been fever-free for 24 hours without the use of fever-reducing medication; AND
  - Their overall illness has improved.

- You are not required to notify families when someone in the program has symptoms of COVID-19 (as long as the case is not confirmed). If you want to communicate something to families about a symptomatic staff member or child, you may let them know that:
  - The person has symptoms, does not currently have a confirmed case of COVID-19, and is not attending the program for at least 10 days (unless they receive a negative lab-based test).
  - All other children may continue to attend the child care program.
  - If they are concerned, they should talk to their health care provider.
  - The symptoms of COVID-19 are very nonspecific, and are often similar to other respiratory viral diseases, including influenza.

**One Confirmed Case in a Program**

- A DOE-contracted program may hear about a positive COVID-19 case in one of the following ways:
  - The DOHMH alerts the program about a positive diagnostic test. (Note: The program should notify the DOE after receiving this information using this intake form. The DOHMH will also notify the DOE about any confirmed cases at DOE-contracted programs).
  - Staff member or parent/guardian self-reports to the program, and the program notifies the DOE, which works with the DOHMH to confirm the positive test result.
- If a staff member or parent/guardian reports a positive COVID-19 case to the program, the program must immediately contact the DOE by completing this intake form.
  - DOE-contracted programs must use this form for staff or child cases in both DOE-contracted AND non-DOE contracted classrooms.
  - Each program must identify two contacts who are authorized to notify the DOE of self-reported cases and receive information back about confirmed cases. This information must be treated as confidential and identifying information on cases should not be shared with the program community or others.
- The DOHMH will investigate whether the person is a confirmed case of COVID-19, and share the results back with the DOE. The DOHMH will also follow up with the program and any confirmed cases directly.
  - Programs can expect to hear back from the DOE whether the case is confirmed by DOHMH within approximately three hours.
- In the event that there is one or more confirmed positive COVID-19 case(s) in a program, the program must adhere to the protocols outlined in the table below, titled **Summary of Confirmed COVID-19 Case Outcomes For DOE-Contracted Programs**.
- The person who has a confirmed case of COVID-19 cannot attend the program, or any other child care program, until all the following are true:
  - It has been at least 10 days since their symptoms started; AND
  - They have not had fever for the last 24 hours without the use of fever-reducing medication; AND
  - Their overall illness has improved.
- If the person never had symptoms, they cannot attend the program for 10 days from the date that the specimen was obtained for their positive COVID-19 test.
- Immediately after confirming the case with the DOHMH, the DOE will reach out to the program with templates for letters to provide to all staff and families enrolled in their program, including families and staff in any classrooms not contracted by the DOE. The DOE will share two different letter templates with programs:
  - **Letter 1 (for presumed close contacts)**: This letter is for staff and families of children who are presumed to be close contacts of the positive case because they are from the same classroom as the individual who tested positive; this classroom will be closed for 14 days. Letter 1 will state that they or their child has likely been in close contact with a COVID-19 positive individual, and will give directions to quarantine for 14 days from the date they were last exposed (if they develop symptoms during this time, they will need to isolate).
  - **Letter 2 (not everyone not presumed close contacts)**: This letter is for staff and families of children who are not presumed to be close contacts of the individual who tested positive. Letter 2 will state that there was a confirmed case of COVID-19 at the program, but that they or their child is not considered a close contact at this time and therefore there is currently no need to quarantine.
- If any children or staff who are presumed close contacts are currently on site when the case is confirmed, programs should follow their existing isolation protocol, contact the parents/guardians of any children who are presumed close contacts for immediate pick-up, and send home any staff members who are presumed close contacts immediately.
- After a case is confirmed, DOHMH will determine the person’s likely “infectious period,” which is the time period when they can spread the virus, to determine whether the child or staff attended the program facility during the infectious period.
  - If the DOHMH determines that the person was not in the program during their infectious period, unless DOHMH or DOE direct the program otherwise, there is nothing else to do.
If the DOHMH determines that the person was in the program during their infectious period, they will work with the program to create a confirmed list of everyone who would have been a close contact (within six feet for at least 10 minutes) of the person in the program during their infectious period.

This list of confirmed close contacts will likely include all of the presumed close contacts (staff and children from the same classroom or home care setting as the individual who tested positive). Depending on the program’s schedule, there may be other close contacts identified. For example, if children or staff move between groups, there may be close contacts in these other groups.

- The DOHMH may provide additional letter templates with further information to confirmed close contacts (including anyone not included in the initial group of presumed close contacts).
- All close contacts must quarantine and cannot attend the program, or any other child care program, for 14 days after their last contact with the infectious person.
  - This is true even if the close contact receives a negative COVID-19 test result themselves during the quarantine period.
- The DOHMH will provide the list of close contacts to NYC Test and Trace Corps for contact intake and ongoing monitoring during the 14-day quarantine.
- Learning must continue remotely for all children from DOE-contracted classrooms who are in quarantine.

Programs must keep the DOE updated on all developments from the DOHMH investigation.

- You should never reveal the identity of the person with COVID-19 with families in your program, or share information about the person with COVID-19. That information is confidential. Maintaining confidentiality will help encourage other people to disclose when they have COVID-19.
- Whenever a case of COVID-19 is confirmed by the DOHMH, programs must close off any areas used by the person confirmed to have COVID-19, and follow the Centers for Disease Control and Prevention guidelines on “Cleaning and Disinfecting Your Facility” when cleaning and disinfecting those spaces.

**Two or More Confirmed Cases in a Program**

- If there are two or more confirmed COVID-19 cases in a program:
  - If the cases are in the same classroom: The program stays open for in-person services, but the affected classroom must remain closed for 14 days; all students and staff in close contact with the positive cases must quarantine for 14 days.
  - If the cases are in different classrooms: The program must close all in-person DOE services for a minimum of 24 hours while the DOHMH and NYC Test + Trace Corps conduct their investigation.
- The DOE will provide the program with the letter template for presumed close contacts described above, as well as a letter template for all other staff and families (not presumed close contacts), notifying them of the closure.
- The DOHMH and NYC Test + Trace Corps will determine if the program needs to remain closed beyond the minimum 24 hours in order to reach the conclusion of the investigation.
- If at its conclusion, the investigation is unable to determine a link between the cases, or if exposure outside the program setting is not confirmed for each case, the program must close all in-person DOE services for 14 days.
  - This closure must include all DOE-contracted classrooms in the program (and any staff who work in any capacity with these contracted classrooms, including program administrators). The DOE strongly encourages closing any non-contracted classrooms as well.
- All DOE-contracted classrooms are required to transition to remote learning services for the duration of any classroom or program closure.
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<tr>
<th>Conclusion of Investigation</th>
<th>During Investigation (for at least 24 hours)</th>
<th>Post Investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. One confirmed case</td>
<td>Close classroom, transition to remote learning.</td>
<td>Classroom remains closed for 14 days; all children and staff in close contact with positive case quarantine for 14 days.</td>
</tr>
<tr>
<td>B. At least two cases in same classroom</td>
<td>Close classroom, transition to remote learning.</td>
<td>Classroom remains closed for 14 days; all children and staff in close contact with positive case quarantine for 14 days.</td>
</tr>
<tr>
<td>C. At least two cases in different classrooms, linked together in program</td>
<td>Close all contracted classrooms in program (strongly encouraged to close non-contracted classrooms) for investigation period of at least 24 hours. Transition DOE-contracted classrooms to remote learning.</td>
<td>All contracted classrooms not under quarantine open post investigation period (at least 24 hours). Classrooms of each case remain closed for 14 days; all children and staff in close contact with positive cases quarantine for 14 days.</td>
</tr>
<tr>
<td>D. At least two cases in different classrooms, linked together by circumstances outside of program</td>
<td>Close all contracted classrooms in program (strongly encouraged to close non-contracted classrooms) for investigation period of at least 24 hours. Transition DOE-contracted classrooms to remote learning.</td>
<td>All contracted classrooms not under quarantine open post investigation period (at least 24 hours). Classrooms of each case remain closed for 14 days; all children and staff in close contact with positive cases quarantine for 14 days.</td>
</tr>
<tr>
<td>E. At least two cases in different classrooms, not linked, but exposure confirmed for each case outside of program setting</td>
<td>Close all contracted classrooms in program (strongly encouraged to close non-contracted classrooms) for investigation period of at least 24 hours. Transition DOE-contracted classrooms to remote learning.</td>
<td>All contracted classrooms not under quarantine open post investigation period (at least 24 hours). Classrooms of each case remain closed for 14 days; all children and staff in close contact with positive cases quarantine for 14 days.</td>
</tr>
<tr>
<td>F. At least two cases in different classrooms, link unable to be determined</td>
<td>Close all contracted classrooms in program (strongly encouraged to close non-contracted classrooms) for investigation period of at least 24 hours. Transition DOE-contracted classrooms to remote learning.</td>
<td>Close all contracted classrooms in program for 14 days (strongly encouraged to close non-contracted classrooms).</td>
</tr>
</tbody>
</table>
MAINTENANCE AND CLEANING SCHEDULE

Trauma Informed Care Considerations:

- Consider creating a daily checklist and schedules among teaching teams to ensure that cleaning responsibilities are shared evenly among teacher/assistant/aide. Check in with staff about their personal needs or concerns around cleaning and maintenance (e.g., allergies to certain cleaning products). Support staff to consider personal preference and needs while evenly distributing cleaning responsibilities.

Programs must ensure adherence to cleaning and disinfection requirements as advised by CDC, NYS DOH, and DOHMH, including Guidance for Cleaning and Disinfection of Public and Private Facilities for COVID-19. Program staff should expect to clean, sanitize and disinfect toys and materials in the classroom throughout the day using registered disinfectants.

General guidelines for cleaning and/or disinfecting toys in child care settings

Programs are encouraged to use toys and materials that are able to be easily cleaned and sanitized. Programs should also put new practices into place to limit the amount of shared materials in the class. For example, an individual set of art materials may be purchased for each child, and labelled and stored separately.

- Toys and materials that cannot be sanitized in between uses should be removed from classrooms. This may include soft dolls, dress-up clothes, puppets, pillows, etc.
  - Machine washable cloth toys should be used by one child at a time or not used at all. These toys should be laundered before being used by another child.
- Programs should also limit sharing of outdoor play or gross motor materials/equipment between stable groups (e.g., balls, tricycles, hula hoops), and clean any shared equipment between uses.
- Children’s belongings must be labelled and stored individually, and may not be shared with other children.
- Toys that cannot be cleaned and sanitized should not be used in child care settings.
- Indoor toys should not be shared between groups of infants or toddlers unless they are washed and sanitized before being moved from one group to the other.
- All toys can spread disease when children put the toys in their mouths, touch the toys after putting their hands in their mouths during play or eating, or after toileting with inadequate hand hygiene.
  - Play with plastic or play foods, play dishes and utensils, should be closely supervised to prevent shared mouthing of these toys.
  - Toys that children have placed in their mouths or that are otherwise contaminated by body secretion or excretion should be set aside until they are cleaned by hand with water and detergent, rinsed, sanitized, and air-dried. You may also clean in a mechanical dishwasher.
- Children’s books, like other paper-based materials, are not considered a high risk for transmission and do not need additional cleaning or disinfection procedures.

Please consult the Department of Environmental Conservation’s (DEC) list of products registered in New York State and identified by the EPA as effective against COVID-19.

When using bleach and water to sanitize or disinfect surfaces, different concentration amounts and saturation times are required to effectively sanitize or disinfect. Ensuring the correct concentration is important to ensure that we do not leave toxic residue on tables for eating or mouthed toys and to ensure adequate sanitizing/disinfecting. In addition, the bleach solution should be made daily as the mixture starts to degrade
once mixed and exposed to light.

<table>
<thead>
<tr>
<th>Surface</th>
<th>Mixture</th>
<th>Time Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food Surface:</strong> tables that children eat at, high chair trays, counters food is served on, etc.</td>
<td>1/2 teaspoon bleach and 1 quart of water</td>
<td>The solution should be sprayed on and must remain on the surfaces for at least 2 minutes</td>
</tr>
<tr>
<td><strong>Surfaces in contact with bodily fluids:</strong> changing tables, mats/cots that children may drool on or have toileting accidents, etc.</td>
<td>1 tablespoon bleach and 1 quart of water</td>
<td>The solution should be sprayed on and must remain for at least 2 minutes</td>
</tr>
<tr>
<td><strong>Toys:</strong> Mouthed toys/Toys in classrooms with infants and toddlers</td>
<td>1 teaspoon bleach and 1 gallon of water</td>
<td>Soaked for at least 5 minutes</td>
</tr>
</tbody>
</table>

**Facilities and Custodial Staff Guidance**

During this time, programs will rely on facilities and custodial staff to create a safe and clean environment for children, families, and staff. Below are some general guidelines that may be helpful to determine adjustments to daily cleaning and disinfection and maintenance routines.

- **Daily cleaning in all buildings should include:**
  - Wiping down all exposed surfaces utilizing an antiviral cleaning product. Special attention is to be paid to horizontal surfaces in the building’s common areas, classrooms, classroom materials, and bathrooms, including food surfaces, outdoor gross motor equipment, diaper changing areas, and napping surfaces. Frequently contacted items, such as drinking fountains, faucet handles, door hardware, push plates and light switches are to be wiped down regularly.
  - A cleaning log must be maintained and completed daily for inspection by DOHMH. A sample cleaning log is available [here](#) (if using this sample, maintain a separate log for each room/area).

- **Ventilation systems:**
  - At a minimum, ensure the program has operable windows that include screens that can be kept open when practical.
  - Ensure filters in window air conditioning units are cleaned weekly and replaced frequently. You should consider upgrading to HEPA filters of the appropriate size and thickness.
  - Regularly check both supply and exhaust ventilation systems (i.e., bathroom and kitchen exhausts) for proper operation.
  - Where applicable, HVAC equipment should be operated with maximum airflow to ventilate and “air purge” buildings. Before using in warmer months, ensure that your licensed HVAC contractor has changed the unit from heating to cooling. Consider adding ultra violet lighting to the air ducts as this is said to dissolve mold and allergens.
  - Consider using air purifiers where feasible. Be sure the air purifier is large enough for the space.
  - Prioritize areas designated for separating ill children under direct adult supervision.

- **All bathrooms:**
  - Are regularly cleaned and disinfected. The frequency of the cleaning and disinfecting should be depended on the frequency of use.
  - Remain sufficiently stocked with liquid hand soap and paper towels.
• All handwashing sinks are in a state of good repair.

• Cleaning and disinfection should happen throughout the day, especially in common areas such as shared bathrooms, hallways, and on frequently touched surfaces; the staffing plan should account for these needs.

• On-site playground equipment should be cleaned and disinfected at least daily, and high-touch surfaces disinfected after each group’s use.

Upon re-opening the facility to provide in-person services, programs should ensure that all faucets are flushed 5-10 days prior to resuming any child care. All faucets should be flushed at the same time starting with the outlet farthest from the water main for a minimum of 10 minutes using cold water first and then hot water. Additionally, programs should consider, as an extra precautionary measure, implementing a routine practice of flushing all faucets any time water has been stagnant for over 18 hours.

ADDITIONAL RESOURCES

Self-Care Going Home Checklist - consider using this before leaving for the day

Executive Order 202
Executive Order 202.6
Executive Order 202.17
Executive Order 202.18
Executive Order 202.34
Executive Order 205

Escalation Protocol

If concerns arise, please contact:
  • Your assigned Policy Support Specialist; and/or
  • Earlychildhoodpolicy@schools.nyc.gov for support.

Please note all content in this guidance document can be amended, edited or supplemented at any time.