

Evidence and Considerations for School Reopenings

Revision Date: August 6, 2020

With schools in the United States—from preschool, to K-12, to higher education—considering strategies to safely reopen following their closure for the COVID-19 pandemic, we prepared this policy review to support local jurisdictions and school administrators in their planning. It provides emerging evidence that can guide safety protocols, highlights where there is limited research, and features the experiences of school districts and universities across the world.

To inform this document, PolicyLab has been tracking academic literature, scientific pre-prints, global school reopening policies, and guidance from public health and education institutions related to schools, occupational safety, and child health more broadly in the context of COVID-19. We intend for this policy review to serve as a guide from which decision-makers can consider interventions for health protections to reduce transmission risk in a school environment. We caution that data from this pandemic remains sparse; considerations featured in this document are guided by best interpretation of transmission risk, sometimes for SARS-CoV-2, but more often based on experience with other respiratory viruses like influenza. As additional evidence becomes available, our team will update this guidance. For questions or feedback, please reference the contact/author list on page 13.

For those seeking additional sources of information on health and safety considerations for school reopening, the [Centers for Disease Control and Prevention \(CDC\)](#), [UNICEF](#), the [American Academy of Pediatrics](#), and the [American Federation of Teachers](#) provide useful guidance on school-level reopening policies and procedures as well.

All decision-makers should be mindful that as long as there are cases of SARS-CoV-2 in the community, there are no strategies that can eliminate transmission risk in schools entirely. The goal is to keep transmission as low as possible so as to safely continue school activities.

Principles that guide the interventions we highlight include:

- **Early evidence suggests children may be at lower risk from severe disease:** The [evidence to date](#) reveals that, overall, children and adolescents are at lower risk of serious complications from SARS-CoV-2 than adults. The incidence of severe or fatal disease is also less than has been observed during influenza seasons; this past year alone, [185 children died](#) of influenza-related complications. At the same time, the risk is not zero. Although the numbers of children with symptomatic illness are fewer, some who do become sick require hospital-level care, including a small subset of children with [an inflammatory syndrome](#) potentially associated with SARS-CoV-2 that, in rare circumstances, has been fatal. To date, children with comorbid medical conditions, including asthma and immune suppression, have not presented with SARS-CoV-2 in significant numbers; however, consideration of the data with respect to all children with

special health care needs remains a high priority, and health departments should communicate with school officials if signals emerge.

- **There is evidence that symptomatic children spread COVID-19. The role of young children and pre/asymptomatic children in transmission are less clear, lacking strong evidence to confirm their contribution.** Children and youth who contract SARS-CoV-2 often have mild or no symptoms. While adults with mild symptoms and those who are presymptomatic and asymptomatic can spread the virus, the evidence on how likely children are to spread the virus is hard to interpret. Recent data suggests that symptomatic [children carry a similar viral load](#) as adults and since they have, on average, [more daily contacts](#), this evidence would suggest an increased potential to become infected. Though, on the whole, children have experienced a [lower burden of symptomatic and/or identified infection](#). Evidence of reduced [transmission rates](#), especially among [younger children](#), is consistent with the interpretation of data that children are less likely to be infected and that spread occurs most frequently in the context of symptoms. Uncertainty around child transmission is partly because [schools](#) were closed before children could widely contract and spread the virus, though recent outbreaks in [summer camps](#) and reopened [schools](#) in the United States are cause for concern and a contrast to reopenings that have occurred abroad in countries with reduced community transmission rates. In mid-late April, several countries in Asia and Europe reopened schools, with more following in mid-May. [Data](#) from these countries show few outbreaks, mostly occurring in [secondary schools](#). In sum, at this time, the evidence suggests that symptomatic children will play a role in transmission and that schools in areas of elevated transmission, even with safety protocols in place, are susceptible to transmission among students and teachers. As more evidence from these locations becomes available, we will update our guidance.
- **The risk to teachers, staff and caregivers warrants strong safety plans in all school settings:** Data on the [age distribution](#) of educators show that almost 30% of teachers nationally are aged 50 and over, placing them in a risk group for complications from SARS-CoV-2. Enhanced surveillance of teachers and staff is warranted with considerations for flexible attendance policies, supported by paid leave, to encourage staff and teachers to quarantine if they or their household members are symptomatic. Additionally, alternative options for virtual instruction may be considered for teachers with underlying conditions in classroom settings where sufficient physical distancing cannot be achieved. Virtual instruction opportunities will likely increase in response to periods of quarantine and with any use of staggered/hybrid scheduling.
- **Safety guidance should extend beyond schools to clear instructions for families to mitigate transmission risk when children are home:** We would advise school districts to work with health departments and local health care systems to disseminate hygiene and disinfection strategies for transmission prevention at home.

This may include reminders for increased hand washing, laundering, and surface disinfection for items traveling between school and home. Additionally, schools should provide clear regulations around early identification of illness and school absence/quarantine procedures for symptomatic children with SARS-CoV-2 infections and their siblings, as well as for children with infected household members. Flexible online learning options are needed on a short-term basis for children during periods of quarantine and, on a longer-term basis, remote options are needed for families with older or medically at-risk caregivers who decide to prioritize home instruction during periods of active community transmission. More stringent school sick policies will likely broaden interest in paid leave policies for working families during periods of heightened community transmission.

- **Selective strategies will be important to accommodate for local area differences and unique educational settings:** While many health and safety strategies will be shared across school environments, some considerations will be unique to schools with resident students (dormitories at higher educational institutions or boarding schools) versus schools in which children and adolescents commute every day. There are significant variations as well in student body size; teacher-student classroom ratios; structural environments (e.g., ventilation, classroom infrastructure), settings (e.g., urban, rural, student modes of transportation), and weather-related factors. For that reason, each school must consider a wide range of choices to accommodate their local needs while prioritizing strong practices of hygiene and disinfection, distancing, and robust plans for surveillance and quarantine practice.

Guidance on Community Transmission Thresholds for School Reopening

This section reviews suggested thresholds of community transmission rates for closing or reopening schools. Beyond these ceiling thresholds, school, sports and extracurricular group activities may experience increased risk of transmission.

These ceiling thresholds do not replace current guidelines for sports, activities and school infection control that are operating lower than these thresholds. Schools may opt for more conservative thresholds (e.g., New York City announced 3% test positivity for school opening, compared to 5% for New York state).

Additionally, case transmission within classrooms, cohorts or schools may close schools at much lower thresholds than the ones suggested below. These community transmission thresholds are guidelines to identify reopenings that may warrant health department review.

Threshold recommendations:

Testing positivity is based on a 7-day rolling average of testing positivity by county, often available through the state department of health. Daily case incidence is based on a 14-day rolling trend.

- **School**
 - **9% or greater test positivity and evidence of increasing 14-day trend of case incidence:**
 - Revert to online schooling only
 - **5% to 9% test positivity and evidence of stable or declining case incidence:**
 - Continue in-class or hybrid instruction if previously in-class
 - **Less than 5% test positivity and evidence of stable or declining case incidence:**
 - Reopen schools previously online for in-class instruction

- **Sports & Activities**
 - **9% or greater test positivity and evidence of increasing 14-day trend of case incidence**
 - Suspend all team/group competition and group sports training, revert to individual or online training and activities
 - **Less than 9% test positivity:**
 - All sports may do individual-level drills and distanced and/or masked group training
 - Lower-contact sports or activities with the ability to distance athletes or participants during competition (e.g., baseball, softball, track, swimming, golf, science club competitions) may continue to scrimmage or pursue team competition under local health department guidelines, but would be recommended to keep those events local or isolated with a couple of partner schools or teams in the area
 - Higher-contact sports or activities without the ability to distance athletes or participants (e.g. wrestling, football, basketball, soccer, lacrosse, field hockey, water polo, chess competitions, band)
 - Team competitions should only be permitted with another team whose local area positivity rates and daily case incidence fall within these guidelines

Outbreaks within schools must supersede these guidelines. If an outbreak occurs within a school, districts should consult with their local department of health for guidance.

Additionally, schools or districts could opt conservatively to make decisions short of these thresholds based on tolerance of risk. Special exceptions might be considered if contained outbreaks (e.g., nursing home or prison outbreaks) explain elevated community rates, or if the

school community is deemed to have lower rates than community statistics because it is a boarding or private school.

Schools may choose to prioritize special populations for in-school learning, such as children with special education needs, and opt for alternate thresholds for these populations to allow for maintenance of contact during periods of higher transmission. These decisions should be made in consultation with local departments of health.

Review of Interventions that May Reduce Transmission Risk Among Children Attending School

This section reviews potential interventions that may assist schools in reducing transmission risk for schools in communities with transmission rates that allow for school reopening. In each section, we highlight the interventions supported by evidence.

K-12 Interventions

General Considerations:

- **Flexible attendance policies for students, teachers and staff:** Flexible attendance policies should be considered for students, teachers and staff with: (1) signs of symptoms or confirmed illness, (2) household members with a positive test, or (3) households with high-risk caregivers or siblings.
 - Flexible attendance policies for symptomatic individuals have [evidence](#) of effectiveness in reducing influenza transmission.
 - Virtual learning accommodations should be considered to maintain continuity of education for students during periods of quarantine.
- **Adjustment of school calendars:** Schools might consider starting the school year earlier in anticipation of a longer shutdown period in the winter and to reduce student exposure to concurrent community spread of influenza and SARS-CoV-2.
- **Increased capacity of school health services:** Schools might augment staffing of school nurses or other designated personnel to strengthen school health service capacity, even during periods of altered schedules/hybrid learning protocols or student quarantine. Protocols for individual quarantine and periods of “school dilute,” “mixed school/home,” and “home only” might consider continuity of the following services: medication dispensing and adherence monitoring; speech, motor skills and other school-based therapies; and mental health and counseling services. Counseling services are a necessary school support for children and may play an important role for youth who have experienced household stress and trauma during the pandemic. Schools may also wish to support grief counseling for students who have experienced loss.
- **Maintenance of up-to-date immunization schedules and influenza vaccinations:** Schools should promote influenza vaccination education and leverage school communications, [facilities](#), and/or health sector partnerships to deliver immunizations to students upon school re-entry and reduce risk for influenza.

- In light of decreased access to preventive care during the shelter-in-place period, [more students](#) may be out of vaccination schedule compliance.
- Schools should work collaboratively with public health departments and health care providers to facilitate access to immunizations in a timely manner to reduce immunization-related school exclusion for children.
- **Increased transportation options:** Altered school schedules and policies to promote student physical distancing have implications for student transportation. It may be important to increase student distancing in transit to and from school. School buses will need protocols for increased cleaning and disinfection. Student masking on buses, public transportation, and in carpools is an important safety protocol. Hand hygiene upon entry to school should be prioritized.
- **Flexing team sports, music programming and other recreational activities in relationship to community risk:** Schools should consider opportunities for safe exercise for students. [CDC guidance](#) has been issued on sports activities. [Additional information](#) on sports is available from Children’s Hospital of Philadelphia. Group-based music programming (e.g., band, orchestra, choir) should consider transmission risk-mitigation protocols to address: hygiene, disinfection of equipment, distancing during practice and competition and numbers of participants. Due to potential increased risk of droplet transmission, physical distancing should be prioritized for wind instruments and choir/singing. In periods of elevated community spread, schools may need to consider cancelling or postponing competitions and other sports, music and recreational events.
- **A focus on strong school communication strategy:** Family and caregiver communication about protocols and schedules will be critical. Schools should be particularly mindful of frequent communications that are accessible in non-English languages and to all caregivers (this is particularly important for children residing with grandparents or other kin or foster caregivers).

Sanitation & Hygiene:

Sanitation procedures are critically important in school settings as the current evidence (as of May 11) suggests fomite transmission in children is a primary concern. **Schools should disinfect at regular intervals throughout the day and emphasize increased student and staff hand hygiene (in compliance with [CDC guidance](#)).** Teachers and staff will need rigorous and routine refresher training on proper hygiene, distancing and personal protective equipment protocols.

- Shared and frequently touched surface disinfection should be prioritized, particularly door handles, light switches and faucets. Additionally, desktops should be disinfected between classroom rotations.
- Additional considerations may include minimizing sharing of electronic devices (e.g., tablets, calculators) or disinfecting between use; keeping children’s belongings separated in labeled cubbies, containers or desks; and limiting outside objects brought into schools.

- Procurement of sanitation supplies such as hand sanitizer, soaps, disinfectant, and masks should begin in advance of school re-opening. Disinfectant supplies should be [OSHA- and CDC](#)-approved. Resource-constrained schools may require assistance in acquiring bulk supplies.

Symptom Surveillance:

Surveillance and testing strategies (for students, teachers, staff and families) will need to be adaptable to the school setting: Comprehensive ongoing symptom surveillance could include routine symptom checks through on-site, app- or web-based reporting; selective temperature screening; and absence monitoring. Surveillance activities should include and prioritize teachers and staff, who are at increased risk of morbidity and may present an increased transmission risk to children if infected.

- Surveillance should seek to identify students, teachers, and staff who are likely ill or exposed by family/household members. Those who are identified would be considered for exclusion/absence policies in accordance with [American Academy of Pediatrics](#) and CDC recommendations. Virtual instruction can be provided during periods of quarantine for students who are not symptomatic.
 - At a school level, the [CDC currently recommends](#) a short-term (2-5 day) dismissal of all students and staff for cleaning, disinfection, and coordination with local public health officials following confirmation of an infected person in the building.
 - Symptom screening should use a case definition based on current research ([CDC](#)). We propose the following set of symptoms for surveillance:
 - *Two of the following: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)*
OR
 - *At least one of the following symptoms: cough, shortness of breath, or difficulty breathing*
- Importantly, temperature checks alone are **insufficient** for assessing COVID-19 illness in staff or students. Temperature checks, if performed, should be a part of a broader symptom screening effort.
- Schools will need to consider the appropriate staffing of school nurses or other certified health personnel to lead symptom surveillance and quarantine protocol activities or coordinate with state or local public health departments or health care systems to address workforce shortages.
 - Partnerships with a public health departments or health systems may be beneficial in protocol development and reporting procedures.
- Child care centers have [demonstrated](#) successful school-level symptom surveillance via web-based reporting that have detected outbreaks early. [Participatory surveillance](#) approaches may be considered for adoption in school environments.

Quarantine and School Absence Policies for Symptomatic and Exposed Persons:

- The following guidance is provided for when a student or staff member screens or tests positive for COVID-19.
 1. **Symptomatic individual/child with test positive:** exclude for 10 days from symptom onset AND at least 24 hours after fever resolution (if present) AND improved respiratory symptoms
 2. **Symptomatic individual/child not tested:** exclude for 10 days from symptom onset AND at least 24 hours after fever resolution (if present) AND improved respiratory symptoms
 3. **Symptomatic individual/child determined to have an alternate cause or illness by their primary medical doctor:** exclude until afebrile for 24 hours (if fever present) and symptoms improving
 4. **Symptomatic individual/child with test negative:** exclude until afebrile for 24 hours (if fever present) AND improved respiratory symptoms
 5. **Exposed and asymptomatic:** exclude for 14 days from last exposure if remains asymptomatic; exclude until meets criteria #1/2 if becomes symptomatic

Direct exposure: When an individual (student or staff) is within 6 feet distance for more than 15 minutes during a 24-hour period during or before symptom onset of someone who has been diagnosed with COVID, the individual needs to follow quarantine procedures.

- **Indirect exposure:** When an individual (student or staff) is exposed to someone who has had direct exposure to someone who has been diagnosed with COVID, no quarantine is needed.

There is no role for testing to get a “negative test” to clear a child to return to school. The COVID-19 positive individual does NOT need a repeat COVID test or a doctor’s note in order to return to the center.

- If a child or staff member has a confirmed diagnosis of COVID-19: Call the local or state health department for further instructions.
- All children and staff in the same classroom or who have come in close contact with (direct exposure defined as greater than 15 minutes of interaction less than 6 feet away) should quarantine at home unless given alternate guidance from health department officials. Anyone who develops symptoms during that time should contact their healthcare provider and schools should follow guidance #1/2 above.
- If a household member of a student or staff member has returned from travelling and has a geographic exposure that the student or staff member does not have, the student or staff member does not need to quarantine. To minimize the risk of in-house transmission, the family could attempt in-home isolation of the traveler until the end of their quarantine period. If the traveler becomes ill and the student or staff has direct exposure to this family member within 24 hours before or during symptoms, the staff or student needs to follow quarantine procedures.

- Decisions about classroom or school quarantines should consider overall community and school-level spread. Schools should seek to preserve on-site instruction for as many students as possible. In circumstances of low circulating cases within the community, classroom-contained exposures may not warrant large dismissals.

Masking:

Medical or surgical masks covering the mouth and nose are recommended for staff and all adults in school buildings. Masks provide increased protection when compared to face shields. Face shields provide some protection and may be considered under certain circumstances. N95 masks are not recommended for non-health care settings at this time. Some states and county public health agencies have made mask use mandatory, but typically do not require this of young children. In a school setting, schools will follow state education and health department guidance on masking, and may choose to adopt local county public health masking mandates if they are present. More specific considerations on masking follow.

- **Medical or Surgical Masks:** In educational settings, medical or surgical masks provide appropriate protection against COVID-19 transmission. Medical or surgical masks provide superior protection to cloth masks and face shields.
 - To be effective, face coverings (surgical or cloth masks) should always cover the nose and mouth.
 - If using a disposable mask, staff should use a new mask each day.
 - While cloth masks (or neck gaiters and bandanas) do not provide as much protection as a medical or surgical mask, they will help to reduce the risk of virus spread. It is important to wash a cloth mask every day with warm soapy water.
- **Face shields:** Clear face shields do provide a partial barrier to respiratory droplets and may be considered, especially for those working with children with hearing loss who depend on lip reading and facial expressions to aid their communication, or by speech/language therapists during therapy sessions.
 - Clear face shields may also be helpful with young children or children with autism spectrum disorder.
 - **Clear masks or masks with clear mouth panels** may also serve to support youth in need of visual facial cues. Clear masks provide increased protection as compared to shields, particularly in situations where physical distancing is less than 6 feet.
 - When used alone (without a mask), face shields are preferred for situations where physical distancing can be achieved.
 - Face shields should be wiped down daily with soapy water or a spray cleaner and allowed to air dry.
- **Goggles:** Goggles, particularly when face shields are not being used with/without a mask, can prevent respiratory droplets from entering the tissue around the eye, and thus provide an additional element of protection against infection.
- **When masking children, teachers and school districts should consider the following:**

- Babies and children younger than 2 years old should NOT wear masks due to risks of suffocation.
- Masks may be considered for children age 2 and older who are mature enough and physically capable of wearing one.
- Enforcement of masks should be developmentally appropriate, especially in young children and children with disabilities.
- Any child unable to remove a mask themselves in the event of an emergency should NOT wear a mask.
- Children should never wear masks during nap times and times of increased physical activity.
- Cloth masks must be laundered daily with warm soapy water.
- Not all children will tolerate wearing masks—it may be most difficult for children with a small number of specific health conditions, sensory differences or behavioral challenges. Most schools will need to adopt a flexible policy for medical exemptions. Clear protocols for exemptions should be developed. Coordination between medical teams, parents and educators can help determine who is unable to wear a mask.
 - Some children who are unable to wear a medical mask can learn to wear a face shield or cloth face covering.
- Child mask wearing should be emphasized during drop-off/pick-up times, bathroom breaks and hallway transitions.
- It may be difficult to require a child to wear a mask throughout the entire day. When there are periods of physical distancing of at least 6 feet, mask breaks may be considered. Mask breaks should occur when prompted by the teacher and while students are seated quietly in order to reduce risk. Ideally, mask breaks will be a duration of 15 minutes or less.
- There are many resources available to help children adapt to mask wearing. Some tips that we share with families include:
 - Allow children to select their mask and design.
 - Beloved stuffed animals, dolls or action figures can also practice mask-wearing.
 - Parents can model mask-wearing behavior.
 - Practice wearing a mask in a safe space before a child leaves home.
 - Children can read social stories about mask-wearing.

Ventilation:

Schools should consider increased ventilation in learning spaces and hallways (CDC, 2020). Holding classroom activities in outdoor spaces or larger school spaces (e.g., auditoriums, gymnasiums) instead of small classrooms and using windows and open classroom doors for cross-ventilation can be considered.

- Ventilation is an intervention to reduce transmission of respiratory illnesses in community (non-health care) settings (WHO 2019, Nature 2019). [Emerging data](#) from COVID-19 suggests that spreading events are less likely to occur in outdoor areas.

- Urban school environments may have limitations with outdoor space access, outdoor air quality or safety. If alternative ventilation options cannot be deployed, an enhanced focus on other means of on-site distancing, class size reduction, and/or flexible scheduling may be weighed as alternative strategies to minimize transmission risk.

Physical Distancing:

Schools should prioritize selective distancing measures, given strong evidence of their effectiveness in reducing transmission. Distancing via smaller teacher-student ratios and physical distancing of desks is being widely implemented among countries that have reopened.

- **Classroom considerations:**
 - 6-foot physical distancing is preferable to the 3-foot recommendation from the World Health Organization.
 - Classroom arrangements should plan for teacher and aide distancing from students, in addition to student-student distancing.
 - Teacher/aide masking is essential in situations where distancing is not possible.
 - Students should all be facing the same direction, rather than facing one another.
 - Table partitions may provide protection when distancing is not feasible.
 - [Hybrid virtual/on-site](#) instructional models have been proposed as a strategy to reduce on-site class size.
 - Hybrid models would need to be supported by broad access to technology. In some areas, community buildings such as libraries or recreation centers provide an alternative site for WiFi access on students' virtual learning days.
 - Hybrid models should also consider the needs and impact on workforce participation of caregivers.
 - Before and after care programs often have increased student-teacher ratios, so may require special attention in the administration of additional staffing to meet distancing protocols.
- **Minimizing contact between groups of students in hallways and other small spaces:** Staggering transitions and arrivals and dismissals and one-directional hallway designations are options being implemented in Denmark. Limiting classroom rotations by students (instead having teachers rotate rooms while students remain in place) is another strategy that might reduce hallway crowding.
 - Masking in hallways is an important strategy when distancing cannot be achieved.
- **Considering alternate approaches to student lunch routines:** Crowding and increased social contact in lunchrooms and dining halls may increase transmission risk. Schools may consider classroom-based meals eaten at student desks or increased staggering of meal times in multiple locations of the school with enforcement of physical distancing. Sharing of food should be discouraged.

- **Regulating use of bathrooms and water fountains:** Along with a focus on increased disinfection protocols, schools might regulate social contact and crowding in bathrooms and at water fountains. Disinfection options might include “virostatic” materials for smooth surface disinfection in bathrooms. The provision of hand sanitizer should be considered for use before entering and leaving the bathroom to minimize fomite transmission of the virus to high-touch surfaces. Masking may also be considered in bathrooms.

Cohorting:

Schools can minimize contact between students and teachers by using a small cohort model: This model identifies set groups of student cohorts to spend all day with one another in classes, lunch, bathroom breaks, transitions, and recess. Many elementary schools already function in such a manner, with a set group of students moving together throughout the day.

- Cohorting is a practice to limit the number of exposures and contain spread.
- There is not yet evidence to guide the ideal cohort size, but schools should aim for the smallest groups feasible given staff and space limitations. Schools in [Denmark](#) are trialing this cohorting model with groups of roughly 12 students.
- Extended day programming and sports or extracurricular activities should be considered when identifying cohorts of students and staff. Isolating groups to different exercise and play equipment or zones may limit viral exposure.
- A cohorting strategy works well with staggered days and arrival/departures, breaks, passing periods and transportation. Schools should be mindful of segregating students by racial or economic backgrounds if linking transportation schedules to cohorts.
- Ongoing symptom surveillance will allow small isolated cohorts to move to virtual learning if a cohort begins to show symptoms or an individual tests positive for COVID-19.
- If cohorting is not feasible, schools may prioritize the robust implementation of other safety measures. Even in the presence of a cohort model, the principles of masking, distancing, sanitation, and disinfection still apply.

Special Considerations for Higher Education and Boarding Schools:

Colleges, universities, and boarding schools present unique challenges around high-density shared living spaces, dining areas, recreational spaces and bathrooms. SARS-CoV-2 has been shown to pass most easily indoors, and dorm living is similar to high-transmission facilities like cruise ships and nursing homes. Other respiratory illnesses [have been shown](#) to easily transmit in dorm settings.

For more suggestions for higher education institutions, please consider further information from [Kuali](#), [Inside Higher Ed](#) or the [National Governor’s Association](#).

Sanitation & Hygiene:

- Frequency of cleaning and disinfection protocols focused on dorms, shared bathrooms, gyms/locker rooms and lecture halls should be increased. Specific protocols for heightened disinfection of residential dormitory hallways and shared bathrooms in areas with identified cases or exposures should be considered.
- Frequent communications to students with hygiene and sanitation instructions should be provided in residential and instructional facilities.
- Student access to hand sanitizer and masks should be considered for distribution by schools.
- Libraries and classrooms with shared computers or technology devices should be considered for staggered scheduling of access and frequent disinfection. Increased availability of technology to all students can minimize sharing of devices and risk of fomite spread.

Masking:

- College-aged students may more easily participate in masking protocols than K-12 students.
- Public shared spaces may warrant staff and student masking simultaneously.
- Rigorous, routine training on proper use and washing of masks may be necessary.

Physical Distancing:

- **General**
 - Students may be grouped into cohorts that live, use shared facilities, and attend courses together to minimize contact with other groups. Much like the cohorting model suggested for K-12 groups above, these groups could be used to identify new cases and quickly isolate small groups.
- **Classes**
 - [Hybrid on-site/virtual instructional models](#) are already in use at many higher education institutions. Increased reliance on these models is a strategy to reduce transmission risk.
 - Large lectures can be moved online and smaller classes or tutorials can be moved to larger spaces, such as gymnasiums and concert halls, with increased distancing.
- **Dorms/Living Arrangements**
 - Single or lower-occupancy dorm rooms can be considered, if on-site or full-time enrollment declines.
 - If reliable serology tests become more available, schools might consider, with family consent, shared room assignments with serology negative and serology positive students to minimize potential transmission within the dorm room.
 - When considering residence policies, higher education institutions should prioritize dorms or housing continuity and supports for students who are [housing](#)

[insecure](#), low-income, [parents](#) and LGBTQ youth. This will be particularly important during periods of school closure or limited on-campus residence when community transmission is increased.

- High-density on- or off-campus living such as sorority, fraternity, or cooperative housing may need special regulations to minimize crowding and increase sanitation protocols. As this is likely outside of an institutions' jurisdiction, administrators should work closely with the local health department to enact and enforce regulations.
- **Shared Facilities**
 - Distancing of staff and students in public spaces, especially in classrooms, dining halls and shared facilities may be important.
 - Staggering the use of laundry, gym, and other shared spaces could mitigate potential opportunities for transmission.
 - More regulated dining facility access might be considered alongside delivery of pre-packaged meals during periods of increased community transmission.
- **Large Gatherings**
 - During periods of increasing or high community transmission, schools might restrict gathering size of spectators for large events such as athletic games, socials, parades, homecoming activities or festivals.
 - Enforcement of gathering size limitations might extend beyond college-endorsed events to on- and off-campus parties and regulation of distancing and sanitation protocols of local bars and restaurants frequented by students.

Surveillance & Testing:

The setting of the college or university should drive each school's testing approach. Smaller, remote colleges where most students live on campus will likely have an easier time monitoring and contact tracing. Urban and commuter campuses may need to consider different strategies.

- **Syndromic Surveillance**
 - Schools may be able to implement participatory syndromic surveillance with text- or app-based reporting of symptoms on a regular basis.
 - Class attendance monitoring and selective use of temperature screenings are additional options for early outbreak detection.
- **Testing**
 - Testing protocols may include prioritizing high-exposure staff and students and those staff and students commuting/arriving from areas of high community transmission for targeted testing approaches, as well as the use of pooled testing strategies to clear groups of students—for example, sports teams, certain classes or cohorts (e.g., medical or dental trainees with health care facility exposures). Additionally, testing should be used to identify positive cases when surveillance measures identify a possible hotspot.
 - Testing considered for return to school may consider a stratified sampling approach to assess baseline prevalence of infection. Baseline prevalence data

should guide decisions on whether more testing is required or whether prioritizing symptom surveillance is appropriate.

- **Contact Tracing**

- Schools may have some advantages for contact tracing via access key cards or phone apps.
- Coordination with local public health departments may assist with protocol development, reporting and tracing workforce.

Isolation and Quarantine of Students:

- With adequate safety, hygiene and medical monitoring protocols, sequestered dorms may confer advantages for isolation and quarantine of students in residence outside of community settings.
- Student health services will need to message clear procedures for ill students, including what to do if students notice symptoms, and where to go to seek testing and health care.
- Schools should identify sequestered spaces to quarantine sick and/or exposed students for the duration of their illness and assign specific staff to provide health monitoring and food delivery.
- Students will need access to educational materials during quarantine.
- Ensure online or hybrid course offerings during individual quarantine or periods of increased campus distancing will not delay graduation or affect student loan, scholarship or work-study eligibility. Additional use of online learning approaches will require broad availability of computers and WiFi access to all students.

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