

# Guidance on Managing COVID-19 and Other Seasonal Viruses for Early Care and Education Settings and Families of Children Under 5 Years Old

January 2022

*The following statement is jointly supported by clinical leadership at Children's Hospital of Philadelphia and PolicyLab at Children's Hospital of Philadelphia.*

**Throughout the pandemic, guidance for mitigating COVID-19 risk in children has prioritized those in K-12 educational settings. Little guidance has been developed for children under 5 years of age who receive early childhood education or child care in group settings. Because masking is not recommended for children under 2 years of age and may be inconsistent among toddlers, centers that provide care and/or education for young children have unique challenges in reducing the risk of COVID-19 transmission. Therefore, Children's Hospital of Philadelphia (CHOP) and PolicyLab at CHOP developed this guidance to complement recommendations we released for [students in K-12 educational settings](#).**

Unlike children in K-12 settings, children under 5 years of age have not yet been offered vaccinations and represent the largest unvaccinated age group remaining in the U.S. Fortunately, however, infections with the omicron variant are usually less severe in infants and toddlers, typically characterized by symptoms consistent with other seasonal viral upper respiratory infections. In fact, COVID-related hospitalizations in infants and toddlers today are virtually indistinguishable from those of children with other seasonal illnesses that hospitals routinely encounter every winter when respiratory viruses spread throughout early care and education (ECE) settings.

The less severe spectrum of illness associated with the omicron variant and its similarity to other seasonal viruses present an opportunity to simplify guidance for families with young children who spend time in ECE settings. Such guidance needs to consider and support the multi-faceted importance of ECE settings to families and communities. The ECE sector allows parents and caregivers to participate in the workforce, cultivates social-emotional development in children, and employs and promotes professional training opportunities for individuals in the community. The pandemic has only worsened significant preexisting financial and staffing shortfalls in ECE, and the logistical challenges posed by strict COVID-19 health and safety mitigation measures—while necessary at earlier stages of the pandemic—have been disproportionately felt by ECE settings.

Our new recommendations seek to support ECE settings and families that rely on them with practical mitigation measures that reflect the current state of the pandemic:

- 1. Encourage children over 2 years of age to wear masks whenever feasible and developmentally appropriate during periods of high community COVID-19 transmission.** We have learned over the initial phases of the pandemic that most young children successfully grasp how to wear a mask with appropriate coaching at home and through child care. As community incidence drops, other educational settings may adopt “mask-optional” policies. Given the lower risk of severe infections in younger children, it would also then be reasonable to allow ECE settings to transition to mask-optional approaches. School and center leaders may refer to the [Centers for Disease Control and Prevention \(CDC\)](#) and local health departments for guidance on thresholds for declining incidence.

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2. **Require masking for staff in ECE settings, preferably 3-ply surgical masks, during periods of high community transmission.** Masking during periods of significant COVID-19 spread can prevent absences of staff critical to the operations of ECE settings.
3. **Require children with symptomatic respiratory illness or fever to stay home, regardless of the cause.** COVID-19 tests should not be required when a child has symptoms of a respiratory illness.
  - a. **If testing is not performed**, the child can return to ECE settings after 5 days if the child has not had fever for at least 24 hours without fever-reducing medication (e.g., acetaminophen, ibuprofen) and if their other symptoms are improving.
  - b. **If tested and found to be negative for COVID-19** at the onset of their symptoms, they may return when they are without fever for 24 hours and their symptoms are improving.
  - c. **If tested and found to be positive for COVID-19** at the onset of their symptoms, the child can return to ECE settings after 5 days if they have not had a fever for at least 24 hours without fever-reducing medication and if their other symptoms are improving.
4. **Exposed but asymptomatic young children may continue to attend ECE but should be watched carefully for development of new symptoms.** It is safest to assume that a child who develops new respiratory symptoms within 5 days of exposure to an individual with COVID-19 infection is also infected, unless COVID-19 testing is negative (please refer to guidance provided in recommendation #3).
5. **Encourage ECE staff to get vaccinated and, when eligible, receive their booster dose of the COVID-19 vaccine.** Maximizing immunologic protection among adults in ECE settings will directly benefit other vaccinated individuals and reduce the risk of COVID-19 exposure to children not yet eligible for vaccination.
6. **Encourage parents and other household members older than 5 years of age to get vaccinated and, if eligible, receive their booster dose of the COVID-19 vaccine.**
7. **All ECE staff, household caregivers, and children over 6 months of age should be encouraged to receive the seasonal influenza vaccine.** Preventing illnesses that resemble COVID-19 will keep all individuals within ECE settings healthier.

As the public and health authorities consider these recommendations, we acknowledge that some of our recommendations provide more flexibility than existing CDC and public health guidelines. Specifically, we offer the opportunity for young children diagnosed with COVID-19 or those with respiratory illnesses who are unable to obtain a test to return within 5 days of the onset of illness if their symptoms improve, even if they are too young to reliably mask for an additional 5 days. In so doing, we align our isolation recommendations for COVID-19 infection with established practices for other seasonal viruses.

While these recommendations do not eliminate the risk of COVID-19 transmission in ECE settings, they balance a goal to reduce overall exposure risk with the need for these institutions to continue to operate, allowing children to socialize and caregivers and child care workers to return to work. That said, we recognize that many ECE settings may wait until community incidence drops in the next few weeks before applying all of these recommendations.

These recommendations are meant to help ECE settings navigate a period in which COVID incidence remains high in communities. As case incidence continues to drop toward seasonal lows, most children with respiratory illness will not have COVID-19 but will have an infection with a different seasonal virus. At that time, ECE settings may adopt even more practical strategies to reduce the number of days children with respiratory illness are required to stay home, returning to a long-standing policy that children return once they are without fever and their symptoms improve.