

# FAQ: Support for Children with Special Educational Needs Amid COVID-19

August 2020

Now more than ever during the COVID-19 pandemic, close collaboration between educators, medical professionals and families is needed. Each has an equal commitment and dedication to children with disabilities, and ongoing communication and connection between the members of a child's team will support a strong and safe educational experience for all children.

In July 2020, PolicyLab hosted a virtual conversation among experts on "[Ensuring Support Services for Youth With Disabilities & Special Health Care Needs](#)." This document was created to respond to the many important health- and safety-related questions that were raised by attendees.

The Centers for Disease Control and Prevention (CDC) and the [American Academy of Pediatrics](#) (AAP) have provided guidance for the reopening of schools that outlines detailed hygiene and safety guidelines to inform operations. Additional guidance is needed based on the unique needs of children receiving special education. The challenge will be determining how to carry out the main principles of safety—screening, hand hygiene and disinfecting, distancing, and masking—while still providing individualized education in the least restrictive setting for children ranging in age from 3 to 21 years old with disabilities.

This document reflects emerging evidence that can guide safety protocols and is generated by experts in developmental pediatrics, psychology and infectious disease at Children's Hospital of Philadelphia (CHOP). To inform this document, PolicyLab has been tracking scientific, medical and policy developments around the COVID-19 pandemic. We caution that data from this pandemic remain sparse; considerations featured in this document are guided by the best interpretation of transmission risk, sometimes for SARS-CoV-2, and also based on experience with other respiratory viruses like influenza.

As we interpret the accumulating data, there is information relevant to the issue of infection in children:

- Person-to-person transmission of disease appears to be less frequent between children than between adults. Within households, adults have been found to be a more likely source of transmission to other household members than children.<sup>1,2</sup>
- Widespread transmission has been less frequent in situations where children are in close contact with other children, such as daycare and schools.<sup>3,4,5</sup>
- Children have been less frequently infected than adults and, when infected, have generally had milder illness, except in rare cases.<sup>6</sup>

All education decision-makers should be mindful that as long as there are cases of COVID-19 in the community, there are no strategies that can entirely eliminate transmission risk in child care and school settings. The goal is to keep transmission as low as possible so as to safely continue educational activities—for students, families, teachers and staff. Given the broad age range and variety of special educational needs among children, along with the variation in school settings, it is important to underscore that all safety and hygiene planning should consist of tailored protocols that can be feasibly carried out faithfully and that emphasize interventions that are most likely to reduce transmission. Including families in the creation of these protocols will support feasibility and acceptance of implementation.

### ***What type of masks are the best for staff when working with children with disabilities?***

- When you wear a mask, you are protecting your students from getting sick from any virus that might be in your respiratory droplets. You are also reducing your risk of getting sick from any virus that may be in the respiratory droplets of your colleagues or students. Additionally, masks indirectly serve as reminders to avoid touching faces.
- Medical or surgical masks covering the mouth and nose are recommended for staff and 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.

### **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. If using a disposable mask, staff should use a new mask each day.
  - 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.

### ***Should students be required to wear masks during the school day?***

- 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.
- 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.

### ***Should staff be tested for COVID-19?***

- Routine testing for COVID-19 among staff in the absence of symptoms or exposure is not recommended.
- Similarly, frequent repeated testing presents an unnecessary financial burden to schools and does not increase safety above symptom monitoring with corresponding sick policies for teachers and children.
- Any symptomatic staff, or those who have had an exposure to someone with known or suspected COVID-19, should be excluded from work. They should follow current guidance from their local or state health department about when to seek testing and for how long to quarantine.
  - Exposure includes contact of more than 15 minutes at less than 6 feet of distance of an infected individual with symptoms or within 2 days of symptom onset.
  - For exposures to symptomatic individuals that occur in a school setting, schools should coordinate with their local or state health department for quarantine procedures and contact tracing efforts.
- All staff must continue to engage in safety protocols, even if they have recently tested negative or if they have a history of a documented COVID-19 infection. These safety protocols include masking, increased disinfection and hand hygiene, and distancing as appropriate.
- After following a recommended period of quarantine, a “negative test” for COVID-19 is not necessary for a teacher to return to the classroom.

### ***What are the recommended daily symptom and screening procedures for school staff and children?***

- Daily symptom and exposure screening for both staff and children is recommended strongly as a priority protocol for monitoring illness.
- Symptom screening:
  - Two of the following: fever (measured or subjective), chills, rigors, myalgia (muscle aches), headache, sore throat, new olfactory (smell) and taste disorder(s)

**OR**

  - At least one of the following symptoms: cough, shortness of breath or difficulty breathing

*(Note that all children with a fever should be directed to routine school protocols for exclusion.)*
- Temperature screening:
  - Fever is not a reliable indicator of COVID-19 infection in adults or children. Symptom screening (reviewed above) is a safer illness-monitoring procedure than daily temperature screening.

### ***What actions are recommended when a staff or student has a positive symptom screen?***

- 1) **Symptomatic student or staff not tested:** Exclude for 10 days from symptom onset AND at least 24 hours after fever resolution (if present) AND improved respiratory symptoms
- 2) **Symptomatic student or staff with test negative:** Exclude until afebrile for 24 hours (if fever present) AND improved respiratory symptoms.

3) **Symptomatic student or staff determined to have an alternative cause for illness by their primary medical doctor:** Exclude until fever is resolved without temperature reducing medications for 24 hours and other symptoms improving.

4) **Exposed and asymptomatic:** Exclude for 14 days from last exposure if remains asymptomatic; exclude until meets criteria #1/#2 if becomes symptomatic.

When **returning to school**, the COVID-19 positive individual does NOT need a repeat COVID test or a doctor's note in order to return as isolation/quarantine for the recommended time is sufficient.

***What actions are recommended when a staff or student tests positively for COVID-19?***

1) **Symptomatic child or staff with test positive:** Exclude for 10 days from symptom onset AND at least 3 days after fever resolution (if present) AND improved respiratory symptoms.

2) When **returning to school**, the COVID-19 positive individual does NOT need a repeat COVID test or a doctor's note in order to return as isolation/quarantine for the recommended time is sufficient.

***What is the best way to set up educational plans for individual children with medical complexity?***

- Planning for a safe education will require close collaboration between schools, health care providers and families.
- Specialty care physicians will need to provide a written care plan for individual children to both families and to the school district. This plan should be developed alongside families. By signing a release of information form, physicians can electronically send the care plan directly to the school.
- Coordinate, as needed, with families and specialty care physicians on a plan for surveillance of illness among a child's social network, including educational and school therapeutic staff and family members. In some circumstances, specialty care physicians may recommend surveillance to include testing.

***What are the best practices for children who are at highest risk of spreading bodily fluids (such as saliva)?***

- Children with asthma using nebulizers:
  - MDI spacers should be used instead of aerosol nebulizers during school.
- Children with tracheostomies:
  - Special precautions are recommended when suctioning is done either by a nurse or if a child is self-suctioning.
  - Child precautions include:
    - Ensure child is at least 6 feet from other members of the class before removing their mask.
    - Area around child should be wiped down immediately using the school disinfectant in case there has been any spread of respiratory droplets.
    - If self-suctioning, child should perform hand hygiene before and after suctioning.
  - Staff precautions include:
    - Person performing suctioning should use standard precautions for this procedure: gloves, mask, eye protection.
    - Gowning/use of smocks (including extra shirt) should be considered if the risk of spread of saliva or other bodily secretions is present.
    - Person performing suctioning should perform hand hygiene before and after suctioning.
- Children who require assistance with feeding:
  - Child precautions include:
    - Ensure child is at least 6 feet from other members of the class before removing their mask.
    - Area around child should be wiped down immediately using the school disinfectant in case there has been any spread of respiratory droplets.
  - Staff precautions include:
    - Person performing feeding should use standard precautions for this activity: gloves, mask, eye protection.
    - Gowning/use of smocks (including extra shirt) should be considered if the risk of

- spread of saliva or other bodily secretions is present.
- Person providing feeding assistance should perform hand hygiene before and after feeding.

### ***How can we use physical distancing to minimize student to student exposure?***

- Physical distancing can be especially challenging for children with special education needs, and can be supported through:
  - Ensuring that student and staff groupings are static and as small as possible.
  - Restricting interaction between classes or larger groups of children.
  - Alter classroom environments to support distancing such as arrangement of chairs and tables, limited class sizes and use of clear barriers between students.
  - Eliminating shared materials.
  - Using physical guides to show what appropriate distancing is, including using tape to mark 6 feet intervals on the classroom floor.
- Risks of student to student exposure can be minimized if done in a way that ensures regular hand washing, disinfecting shared objects and consideration of activities that naturally distance children.
- As feasible and appropriate, outdoor time presents a lower-risk environment.
- At a minimum, shared materials should be wiped down at the beginning and end of the day and when visibly soiled or contaminated by respiratory secretions or saliva.

### ***What are the risks of allowing outside contractors such as 1:1 aides and behavioral health aides into the school?***

- Essential outside contractors, such as 1:1 aides and behavioral health aides will be expected to follow the same safety precautions as school staff.
- If aides will be sitting immediately adjacent (less than 6 feet) to a student for an extended period of time, they should be encouraged to wear eye protection in addition to masks.
- If a student drools frequently or has other frequent spread of bodily secretions, aides should be encouraged to wear gloves while providing student support.
- Aides with smaller caseloads are at less risk for exposure.

### ***Should siblings of children with disabilities receive their education in the same location?***

- Siblings of children with special educational needs do not need to alter their educational experiences. If they are attending school in person, children should take the usual precautions described above, including masking and hand hygiene.

### ***Are children with intellectual or developmental disabilities at higher risk for COVID-19?***

- To date, there is no evidence to suggest that children with intellectual disabilities or developmental disabilities are at higher risk for COVID-19.
- There has been some media attention given to increased risk among individuals with disabilities, including autism spectrum disorder. However, this risk seems largely attributable to individuals living in group-home settings.

### ***Are children with medical conditions at higher risk for COVID-19?***

- To date, there is no evidence to suggest that children with well-controlled asthma or many other underlying health conditions are at increased risk for severe COVID-19 illness.
  - Compliance with asthma and other routine preventive medications will reduce the likelihood of unnecessary school absence for children.
- Children with well-controlled diabetes, asthma and repaired/not hemodynamically significant heart disease may return to child care without medical consultation.
  - Follow children's current care plans for underlying health conditions, such as an [asthma action plan](#).
- Children with immunocompromised status, those awaiting transplant, and those with chronic medical conditions needing frequent doctor contacts should consult the specialty physician managing the child's condition prior to child care return for instructions and any needed coordination with the child care pro-

vider.

- For medical child care operators, children with significant neurologic or respiratory complexity (e.g., children with muscular dystrophy or cerebral palsy) may require additional protections in the form of prioritized reduced staff-child ratios and frequent teacher/aide testing to reduce transmission risk.
- Encourage families to update emergency contact information and availability of any needed medications.

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## References

1. (Posfay-Barbe KM et al.) Covid -19- in Children and Dynamics of Infection in Families, *Pediatrics* May 26, 2020
2. Wu Q et al. Co-infection and other clinical characteristics of Covid 19 in children, *Pediatrics 2020 pre-publication release*
3. Heavey L, Casey G, Kelly C, Kelly D, McDarby G. No evidence of secondary transmission of COVID-19 from children attending school in Ireland, 2020. *Euro Surveill.* 2020;25(21):10.2
4. Lee B, Rsazka Jr WV. Covid 19 transmission and children. The child is not to blame. *Pediatrics 2020 pre-publication*
5. Children under 12 may play little role in transmitting Coronavirus (*Netherlands Institute for Health @ [www.rivm.nl/en/novel-coronavirus-covid-19/children-and-covid-19](http://www.rivm.nl/en/novel-coronavirus-covid-19/children-and-covid-19)*)
6. Ludvigsson JF. Systematic review of COVID-19 in children shows milder cases and a better prognosis than adults. *Acta Paediatr.* 2020;109(6):1088-1095. doi:10.1111/apa.15270