ADMINISTRATION FOR CHILDREN & FAMILIES
Office of Refugee Resettlement | 330 C Street, S.W., Washington, DC 20201
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FIELD GUIDANCE – Revised February 1, 2024 (First issued November 30, 2020)

Re: Field Guidance #6 – COVID-19 Procedures for Unaccompanied Children and Care Provider Staff

This field guidance is for Office of Refugee Resettlement (ORR)-funded programs providing care to unaccompanied children (UC), including standard care provider programs and influx care facilities (ICF). This version replaces the COVID-19 intake procedures guidance (FG #6) issued on May 17, 2023. This updated guidance is based on current Centers for Disease Control and Prevention (CDC) guidance and recommendations, adapted for the UC Program.

The key revisions reflected in this document include the following:

- Transition from universal COVID-19 Intake Testing to symptom-based COVID-19 testing at Intake
- Introduction of a list of symptoms that should result in COVID-19 isolation and/or testing
- Revised requirements for testing children after close-contact exposure to COVID-19
- Introduction of additional types of COVID-19 confirmatory tests that can be used when indicated by the COVID-19 testing algorithm
- Discontinued use of the 'COVID-19 Discharge Letter for Sponsors'

GUIDANCE OVERVIEW

DEFINITIONS OF COMMONLY USED TERMS

- **Medical isolation** – Medical isolation refers to separating someone with confirmed or suspected COVID-19 infection to prevent contact with others and to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established criteria for release from isolation.
- **Quarantine** – Quarantine—or 'watchful waiting'—refers to separating individuals who have had close contact with someone with confirmed COVID-19 to determine whether they will develop symptoms or test positive for disease.
- **Close Contact** – For ORR purposes, a close contact is defined as someone who has been within 6 feet of a person with diagnosed COVID-19 (while that person is infectious) for a cumulative total of 15 minutes or more in a 24-hour period (e.g., three 5-minute exposures in one day).
- **Cohorting** – In this guidance, cohorting refers to the practice of isolating or quarantining multiple children together as a group due to a limited number of individual rooms. Children should only be cohorted with 'like' children—meaning confirmed cases of COVID-19 should only be cohorted with other confirmed cases of COVID-19. Children who show *symptoms* of COVID-19 but either have not been tested or are awaiting test results should *not* be cohorted with confirmed cases of COVID-19.
- **Rapid antigen test—** Tests for *current* infection with SARS-CoV-2, the virus that causes COVID-19. These tests detect antigens (protein markers) on the surface of the virus. They can be processed at the point-of-care where the sample is collected. Results are typically available in 15 minutes.
- **Molecular test—** Tests for *current* infection with SARS-CoV-2, the virus that causes COVID-19. These tests detect viral genetic material like ribonucleic acid (RNA). Molecular tests may be lab-based with results available in 1–3 days or rapid, point-of-care tests with results available in 15–30 minutes. Nucleic acid amplification tests (NAAT), such as real-time reverse transcription polymerase chain reaction (RT-PCR), are examples of molecular tests.
- **Symptoms of COVID-19—**For the purpose of making testing and isolation decisions, symptoms of COVID-19 include any of the following: fever or chills, cough, shortness of breath or difficulty breathing, congestion or runny nose, loss of taste or smell, and sore throat. Other symptoms may be considered at the discretion of the child's healthcare provider.

COVID-19 TESTING PROCEDURES FOR CHILDREN

ORR requires that children be tested for COVID-19 in three contexts:

- Upon observation or report of COVID-19 **symptoms**
- Five days after a **close-contact exposure** to COVID-19 (for certain children)
- If attempting to **shorten a child's medical isolation** for release to general program population

Effective February 1, 2024, ORR is discontinuing the requirement that *all* children be tested for COVID-19 upon initial entry into ORR care. **Assessing children for symptoms of COVID-19 and other communicable diseases on *day of arrival* remains *critical*.** Children presenting with or reporting symptoms of COVID-19 at Intake should be tested for COVID-19 following the testing algorithm and instructions outlined in the section, below, "Testing upon observation or report of COVID-19 symptoms."

Effective February 1, 2024, Customs and Border Protection (CBP) will also discontinue COVID-19 testing on *asymptomatic* unaccompanied children. They will continue to test children who present with symptoms of COVID-19 and will share information about confirmed COVID-19 cases through the UC Portal Intakes Tab. If a child arrives in ORR care with a known COVID-19 diagnosis or a known positive COVID-19 test result from CBP, they should be isolated immediately on arrival to ORR care. **No**

confirmatory testing is needed. Isolation dates should be based on available information from CBP. If CBP does not provide symptom onset date or test administration date, use the date of the child's arrival into ORR care as 'Day 0' for isolation purposes.

Testing upon observation or report of COVID-19 symptoms (i.e., Symptomatic Testing)

Children should be isolated in a private room and tested for COVID-19 at the first observation or report of COVID-19 symptoms. COVID-19 testing should be carried out in line with the ORR COVID-19 testing algorithm for symptomatic children and staff (Appendix A). In general, testing of symptomatic children should begin with a COVID-19 rapid antigen test. These tests may be administered by program staff who have been trained in their use. A positive rapid antigen test in a symptomatic person confirms a diagnosis of COVID-19. A negative rapid antigen test in a symptomatic person must be confirmed by another test.

Effective February 1, 2024, a negative COVID-19 rapid antigen test result in a symptomatic person may be confirmed using one of three different approaches: 1) a lab-based PCR/NAAT test; 2) a rapid molecular diagnostic test (i.e., a point-of-care test typically found in a healthcare provider's office); or 3) by administering a second rapid antigen test at least 48 hours after the initial test. When confirmatory testing is indicated, symptomatic children should remain in isolation until confirmatory test results are reported. A positive result on any of the three types of confirmatory tests confirms a diagnosis of COVID-19; a negative result on the chosen confirmatory test rules out COVID-19.

Children diagnosed with COVID-19 using the ORR testing algorithm should complete the indicated isolation period based on their clinical status and readiness for discharge; see sections titled "COVID-19 Medical Isolation for Children and Staff" and "Cohorting Medically Isolated Children with COVID-19" for details.

If COVID-19 is ruled out using the ORR testing algorithm, the healthcare provider should determine whether there are concerns for *other* respiratory infections before clearing the child for release to the general program population.

Children with a documented COVID-19 diagnosis in the past 90 days *should* be tested for COVID-19 when new symptoms arise, but NAAT/PCR tests are not recommended for this population. Review CDC's website for special testing considerations to determine the appropriate testing strategy for this group.

Testing five days after a close-contact exposure to COVID-19 (i.e., Post-Exposure Testing)

Close contacts can be difficult to identify with any precision in a congregate care setting where children are regularly mixing. Effective February 1, 2024, ORR is providing new guidance on *which* children meeting the definition of a 'close contact' will require monitoring and post-exposure testing.

- ***All* children who had close contact with a person with COVID-19** should wear a mask for 10 full days after their last known exposure.
- **Children who had close contact with a person with COVID-19 and are at increased risk of contracting COVID-19 due to duration of exposure—**including but not limited to *roommates* of a COVID-infected child—should be tested for COVID-19 five days after their last known exposure (or sooner if symptoms develop).
- **Children who had close contact with a person with COVID-19 who have certain medical conditions and are at increased risk of developing severe illness** from COVID-19 should be tested five days after their last known exposure (or sooner if symptoms develop).

- A child's vaccination status or use of masks does not modify these post-exposure testing requirements (above). Other groups of children who meet the definition of 'close contact' can receive post-exposure testing at the program's discretion.

There are two options for carrying out post-exposure testing:

- Children can be tested using 1 NAAT/PCR test on Day 5 post-exposure; *or*
- Children can be tested using a series of 3 rapid antigen tests on Days 5, 7, and 9 post-exposure.

A positive result on any test indicates COVID-19 infection. Children testing positive should be isolated; see sections titled "COVID-19 Medical Isolation for Children and Staff" and "Cohorting Medically Isolated Children with COVID-19."

NAAT/PCR tests are not recommended for use on children with a documented COVID-19 diagnosis in the past 90 days. If post-exposure testing is required for a child with a recent diagnosis of COVID-19, review CDC's website for special testing considerations to determine the appropriate testing strategy for this group.

Post-exposure testing requirements should not delay a child's discharge if the child remains asymptomatic. If the child is discharged prior to completing recommended COVID-19 post-exposure testing, please notify the sponsor of the exposure event and the ideal test date.

Testing to shorten medical isolation for release to general program population

Some children may be eligible for shortened medical isolation following a COVID-19 diagnosis. Information on eligibility criteria, timing of testing, and acceptable test types can be found in the section titled "Eligibility for Shortened Medical Isolation: Movement to General Program Population."

COVID-19 MEDICAL ISOLATION FOR CHILDREN AND STAFF

COVID-19 is transmitted more easily in settings where people live in close proximity to one another (e.g., congregate settings like those of the UC Program). As such, congregate settings should adhere to more stringent procedures for COVID-19 medical isolation than the general U.S. population.

General Guidance for COVID-19 Medical Isolation for Children

Children should be placed in medical isolation at the first observation or report of COVID-19 symptoms or at the first positive COVID-19 test result (if asymptomatic). Children with COVID-19 should wear a mask for 10 full days from symptom onset or positive test result. Additional details about masking—including when COVID-infected children may unmask—are provided in the section titled "Mask and Respirator Use."

Cohorting Children with Confirmed COVID-19

Children with *confirmed* COVID-19 can be medically isolated together as a cohort. Cohorting of confirmed cases can help conserve personal protective equipment (PPE) for staff and free up bed space. Children in the cohort can be released from medical isolation as soon as they meet discontinuation criteria outlined in the sections below. One child's release does not affect the isolation release dates for other children in the shared room. Children with confirmed COVID-19 who also have *another* infectious disease (e.g., influenza, varicella) should be medically isolated in their own private rooms and not cohorted.

Discontinuation of Medical Isolation

As a general rule, children can discontinue COVID-19 medical isolation according to the following guidance:

- Those who **never develop symptoms** can discontinue isolation when **10 full days** have passed since the date of their first positive test for COVID-19 (i.e., 'Day 0'). No testing is required to move to the general program population of the facility or foster home on Day 11. These children may be eligible for shortened isolation; see section titled "Eligibility for Shortened Medical Isolation for Children: Movement to General Program Population."
- Those **with symptoms** can discontinue isolation when **10 full days** have passed since symptom onset (i.e., 'Day 0') **and** at least 24 hours have passed since the resolution of fever without the use of fever-reducing medications **and** other symptoms have improved. No testing is required to move to the general program population or foster home on Day 11. These children may be eligible for shortened isolation; see section titled "Eligibility for Shortened Medical Isolation for Children: Movement to General Program Population."

Eligibility for Shortened Medical Isolation for Children: Movement to General Program Population

Some children with COVID-19 may be eligible for shortened medical isolation, allowing them to move to the general program population of the facility or foster home before completing a routine, 10-day medical isolation period (see section, above).

Children are eligible for shortened isolation with movement to general program population after **7 full days** of isolation if they meet the following criteria:

- They do *not* have a weakened immune system (e.g., HIV infection, recent chemotherapy)
- They have *not* been hospitalized for their COVID-19 infection
- They are asymptomatic or their symptoms are improving
- They have been fever-free for 24 hours without the use of fever-reducing medicine
- They have a negative COVID-19 viral test, following one of two acceptable approaches:
    - **ORR-preferred approach:** *Two* negative rapid antigen tests—one test collected on Day 5 or later and a second test collected 48 hours after the first; or
    - *One* NAAT/PCR test collected on Day 5 or later
- They agree to wear a high-quality cloth or disposable surgical mask for the remainder of the 10-day isolation period when they are indoors and around other people

Children who continue to test positive for COVID-19 (on or after Day 5) should remain in medical isolation and complete the remainder of their 10-day isolation as advised in general guidance. Their COVID-19 medical isolation clock does *not* reset; no additional testing is required to move to the general program population or foster home on Day 11.

Eligibility for Shortened Medical Isolation for Children: Discharge Directly to Sponsor

Some children with COVID-19 may be eligible for shortened medical isolation, allowing them to be discharged directly from isolation to their sponsor before completing a routine, 10-day medical isolation period. This option for shortened isolation with discharge directly to a sponsor complies with CDC's community guidelines for COVID-19 isolation; it can be used for unifications that are occurring by air- *or* ground-transport. Children being considered for this type of shortened isolation should *not* be allowed to pass through the general program population before discharge to their sponsor as they *do not* meet more stringent requirements for discontinuing isolation in a congregate setting.

Children are eligible for shortened isolation with discharge *directly* to their sponsor after **5 full days** of isolation if they meet *all* the following criteria:

- They do *not* have a weakened immune system
- They have *not* been hospitalized for their COVID-19 infection
- They are asymptomatic or their symptoms are improving
- They have been fever-free for 24 hours without the use of fever-reducing medicine
- They agree to wear a high-quality cloth or disposable surgical mask for the full duration of their transit and for the remainder of the 10-day isolation period (after unification) when they are indoors and around other people

Testing for COVID-19 (i.e., 'exit testing') is *not* required when shortening isolation for the purpose of discharge directly to a sponsor.

Eligibility for Shortened Medical Isolation for Children Attending Community-based School

Children diagnosed with COVID-19 who are placed in a long-term foster care program **and** who attend a community-based (not an ORR program-run) school should follow their school district's COVID-19 isolation and testing requirements. Generally speaking, this means a return to school after **5 full days** of isolation if they meet the following criteria:

- They do *not* have a weakened immune system (e.g., HIV infection, recent chemotherapy)
- They have *not* been hospitalized for their COVID-19 infection
- They are asymptomatic or their symptoms are improving
- They have been fever-free for 24 hours without the use of fever-reducing medicine

Children who meet criteria (above) must continue to mask within and outside the foster care home until they have completed 10 full days of masking.

General Guidance for COVID-19 Medical Isolation for Staff

ORR care provider staff should be instructed *not* to report to work if they are symptomatic and to leave the workplace (after speaking with a supervisor) if they *begin* to develop symptoms while at the workplace. Staff members with COVID-19 symptoms at home or in the workplace should test with a COVID-19 rapid antigen test or see their healthcare provider for a lab-based test. Those who test positive while symptomatic are confirmed to have COVID-19 and should follow isolation guidance, below.

As a general rule, staff can discontinue COVID-19 medical isolation according to the following guidance:

- Those who **never develop symptoms** (e.g., some who test positive during post-exposure testing) can discontinue isolation when **10 full days** have passed since the date of their first positive test for COVID-19 (i.e., 'Day 0'). No testing is required to return to on-site work on Day 11. Staff may be eligible for shortened isolation; see section titled "Staff Eligibility for Shortened Medical Isolation."
- Those **with symptoms** can discontinue isolation when **10 full days** have passed since symptom onset (i.e., 'Day 0') **and** at least 24 hours have passed since the resolution of fever without the use of fever-reducing medications **and** other symptoms have improved. No testing is required to return to on-site work on Day 11. Staff may be eligible for shortened isolation; see section titled "Staff Eligibility for Shortened Medical Isolation."

Staff Eligibility for Shortened Medical Isolation

Staff with COVID-19 may be eligible for shortened medical isolation, allowing them to return to on-site work before completing a routine, 10-day medical isolation period (see section, above).

Staff are eligible for shortened isolation after **7 full days** of isolation if they meet the following criteria:

- They do *not* have a weakened immune system (e.g., HIV infection, recent chemotherapy)
- They have *not* been hospitalized for their COVID-19 infection
- They are asymptomatic or their symptoms are improving
- They have been fever-free for 24 hours without the use of fever-reducing medicine
- They have a negative COVID-19 viral test, following one of two acceptable approaches:
    - **ORR-preferred approach:** *Two* negative rapid antigen tests—one test collected on Day 5 or later and a second test collected 48 hours after the first; or
    - *One* NAAT/PCR test collected on Day 5 or later

Staff who continue to test positive for COVID-19 at the time of testing (on Day 5 or later) should remain in medical isolation and complete the remainder of their 10 days as advised in general guidance. Their COVID-19 medical isolation clock does *not* reset; no additional testing is required to return to on-site work on 'Day 11.'

Staff diagnosed with COVID-19 should mask for 10 full days from the date of symptom onset or positive test result (if asymptomatic). Staff who meet criteria (above) for shortened medical isolation *may* return to on-site work before Day 10 but must continue to mask until they have completed 10 full days of masking.

CLOSE-CONTACT EXPOSURE TO COVID-19

***All* children and staff who had close-contact exposure to a person with COVID-19 should wear a mask for 10 full days from the date of last exposure.** Masks should be worn while indoors; they may be removed when eating, drinking, taking medication, bathing, and sleeping.

Some children with a close-contact exposure should be tested for COVID-19 five days after their last known exposure (or sooner if symptoms develop). See the section (above) titled "Testing five days after a close-contact exposure to COVID-19" for details as to which exposed children require Post-Exposure Testing.

Post-Exposure Testing for COVID-19 is also recommended for staff members as part of CDC's general guidance for people exposed to COVID-19.

INITIAL MEDICAL EXAM, VACCINATIONS, AND SERVICES FOR CHILDREN WITH COVID-19

- The Initial Medical Exam (IME) should be initiated within 2 business days of a child's arrival to the program, regardless of whether the child is symptomatic or has tested positive for COVID-19. The IME is not considered a routine medical exam that can be delayed, as children newly entering ORR care might have undiagnosed urgent medical needs or might need rapid vaccination for post-exposure prophylaxis to communicable diseases. Every effort should be made to complete all IME components in this timeframe.
- Per existing IME guidelines, children with influenza-like illness (fever with *either* cough or sore throat) and children with symptoms of strep throat (sore throat and fever *without* cough) should be tested for influenza and strep throat, respectively, at the time of IME.
- Children should receive the most up-to-date COVID-19 vaccine recommended by CDC guidance. Children who are in medical isolation for COVID-19 at the time of their IME should have their COVID-19 vaccine delayed until they meet criteria for discontinuing medical isolation.

- All other (non-COVID-19) IME vaccines, including the influenza vaccine when seasonably available, should be administered at the IME in accordance with CDC guidance based on symptom severity:
    - Children who are asymptomatic or who are symptomatic with mild illness (e.g., low grade fever; cold, runny nose, or cough; ear infection; mild diarrhea) should receive IME vaccinations on time.
    - Children who are symptomatic with moderate to severe illness should have their IME vaccinations delayed until the child has been cleared by a medical provider.

In accordance with ORR Unaccompanied Children Program Policy Guide, section 3.4.6, children held in medical isolation should continue receiving tailored services when feasible. These services include access to medical, urgent dental, mental health, legal, and educational services. In addition, care providers should ensure that medically isolated children engage in social interaction with staff and are able to correspond with approved contacts via telephone, video conferencing, and mail, per ORR policy. ORR care providers must continue to supervise children and youth in their facilities, including children and youth in medical isolation, in accordance with State licensing requirements and UC Policy Guide, section 4.4.1.

TREATMENT AUTHORIZATION REQUESTS FOR COVID-19 TESTING

- COVID-19 rapid antigen and molecular tests do *not* require a Treatment Authorization Request (TAR). Providers will be able to bill PCU for testing without an authorization number.
- Providers should *not* bill PCU for rapid antigen or molecular testing that is performed on-site at the program AND administered by program staff using tests purchased by the program or ORR.

DOCUMENTING & REPORTING FOR COVID-19

Documentation & Reporting Requirements for Children

Effective February 1, 2024, care providers will no longer document COVID-19 testing in a 'Public Health Investigation' report in the UC Portal Health Tab *unless* the child is a known close-contact to a person with COVID-19 *and* meets initial requirements for Post-Exposure Testing (described above). Documentation of symptomatic children and their related COVID-19 testing should occur as with any other illness (e.g., enter a Medical Complaint for a child if symptoms are identified before or after the IME). Children's COVID-19 test results should be reported to authorities as required by state and local public health guidance and licensing requirements. This guidance may differ depending on test type and test result.

Reporting Requirements for Staff

If staff testing for COVID-19 is performed on-site at the program for any reason (e.g., at the request of the health department) and tests are being self-collected *or* administered by program staff members, these COVID-19 test results should be reported to authorities as required by state and local public health guidance and licensing requirements. This guidance may differ depending on test type and test result. Individual staff test results, diagnoses, and/or exposure events do not need to be reported to DHUC; however, COVID-19 outbreaks involving staff members should be reported to DHUC.

MASK AND RESPIRATOR USE

Programs must make high-quality cloth or disposable surgical masks available to children and staff who need or would like to use them.

Indications for Mask Use

Children and staff who have been diagnosed with COVID-19 should wear a mask for **10 full days from the date of symptom onset or the date of positive test** (if asymptomatic). Children and staff who have had a close-contact exposure to a person with COVID-19 should wear a mask for **10 full days from the date of last exposure.**

Children are exempt from masking requirements if they are younger than 2 years of age, have difficulty breathing, or are unable to remove the mask without assistance.

When masks are indicated based on a recent COVID-19 diagnosis or exposure, they are *not* required to be worn outdoors; *not* required to be worn when alone in a room; and can be removed when eating, drinking, sleeping, bathing, and taking medications. Children with confirmed COVID-19 may also remove their masks when they are cohorted in a bedroom with other children confirmed to have COVID-19.

Indications for Respirator and Personal Protective Equipment (PPE) Use

Staff must adhere to higher levels of PPE (e.g., N95 respirators) when working with children who are medically isolated for COVID-19. Details can be found in the Table, below.

Table 1: Masking and PPE requirements for children and staff when indoors*

	High-quality cloth or disposable surgical mask or international respirator	N95 respirator	Eye Protection	Gloves	Gown/ Coveralls
Children					
Children with confirmed or suspected (i.e., showing symptoms of) COVID-19*	X				
Asymptomatic children in the general program population with a known exposure to COVID-19*	X				
Staff					
Staff who have been diagnosed with COVID-19 in the past 10 days (cleared to return to on-site work)*	X				
Staff who have been exposed to COVID-19 in the past 10 days*	X				
Staff having direct contact with children under medical isolation for COVID-19		X	X	X	X
Staff performing COVID-19 testing or working with children in an 'Intakes' setting where COVID-19 status is unknown		X	X	X	X

* Masks should *not* be worn by children younger than 2 years; anyone who has trouble breathing; or anyone who is unable to remove the mask without assistance. Masks are not required to be worn when outdoors or when alone in a room. Masks can be removed when eating, drinking, sleeping, bathing, or taking medication.

ENHANCED STRATEGIES DURING PERIODS OF HEIGHTENED CONCERN FOR COVID-19

The COVID-19 prevention strategies listed above, including testing, medical isolation, and vaccination should be used at all times. These strategies are re-evaluated regularly by ORR in consultation with CDC. ORR care providers should use additional enhanced strategies to mitigate COVID-19 transmission during periods of heightened concern for COVID-19. 'Heightened concern' for the purposes of initiating enhanced strategies is defined as:

1) State or local health department declaration that the program's geographic area is experiencing high levels of COVID-19—measured by Emergency Department (ED) admissions and hospitalizations due to COVID-19; *or*
2) Increased transmission within the facility (e.g., multiple COVID-19 diagnoses among children who have been at the facility for 10 days or more at the time of their first COVID-19 symptom or first positive test, if asymptomatic). Results of testing at intake are *not* recommended as an indicator of transmission within the facility, since infections identified at intake most likely occurred elsewhere; *or*
3) State or local health department declaration that the program is experiencing a COVID-19 outbreak; *or*
4) ORR notification that there are facility-specific concerns for COVID-19 transmission.

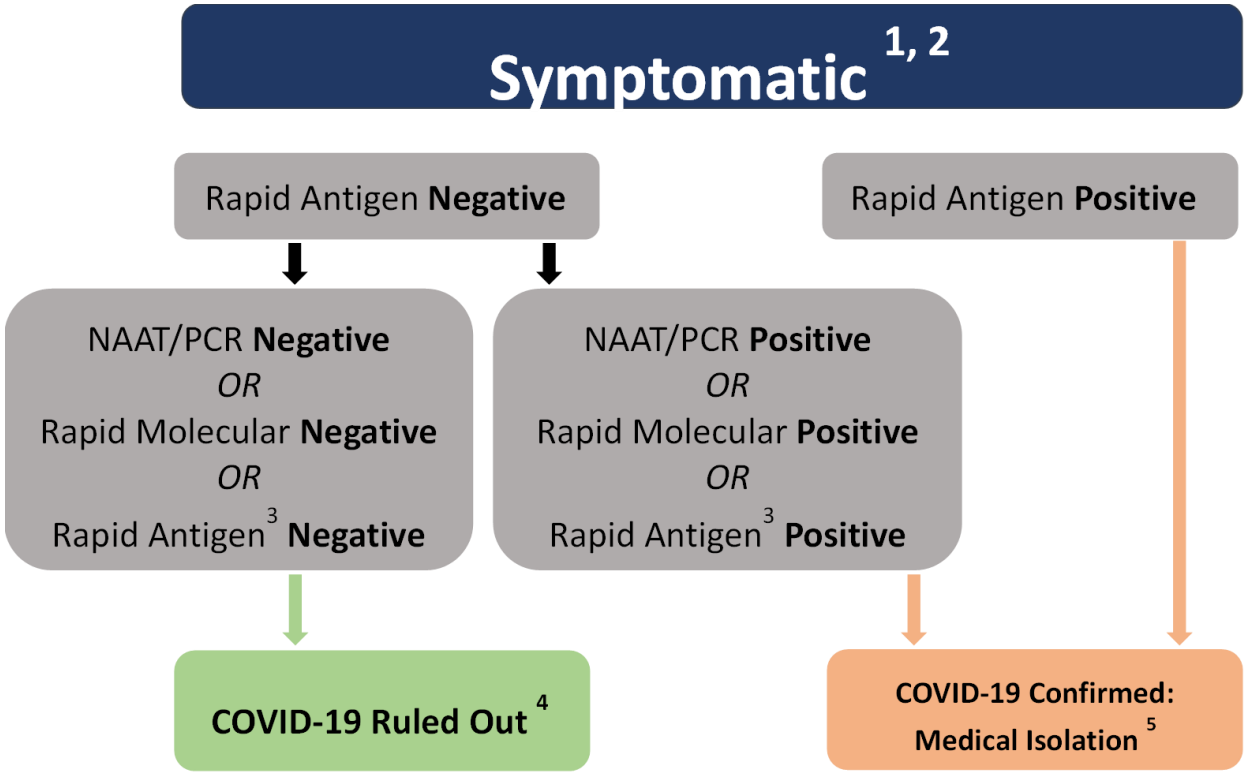
If a program has indicators for heightened concern (above), they should seek guidance from DHUC (DCSMedical@acf.hhs.gov). Enhanced strategies recommended by DHUC *may* include universal masking, reinstatement of universal intake testing, surveillance testing (i.e., testing asymptomatic children), or the temporary reinstatement of a quarantine period for exposed children, among other measures. The recommended approach will depend on facility-specific indicators and risks.

TRANSFER AND DISCHARGE PROCEDURES

Children being transferred to another ORR-funded program or discharged from ORR care should receive a brief assessment for communicable disease symptoms on the day of transfer or discharge, including—but not limited to—new or worsening respiratory symptoms (e.g., sore throat, cough, fever). This symptom assessment may be completed by program staff. Children exhibiting or self-reporting new or worsening signs of a communicable disease on the day of transfer or discharge should have their transfer or discharge delayed and should be seen by a healthcare provider.

Appendix A: COVID-19 Testing Algorithm for *Symptomatic* Children and Staff **(Revised: Feb. 1, 2024)**

- **Children must be tested and staff should seek testing at first observation or report of COVID-19 symptoms.**[1]
- This algorithm is *not* for use with children or staff receiving testing as part of COVID-19 Post-Exposure Testing or Early Release from Isolation Testing. See *Field Guidance #6*.
- If initial COVID-19 testing is a laboratory-based NAAT/PCR, no confirmatory testing is necessary; start algorithm based on NAAT/PCR result.



[1] For the purpose of making testing and isolation decisions, symptoms of COVID-19 include any of the following: fever or chills, cough, shortness of breath or difficulty breathing, congestion or runny nose, loss of taste or smell, and sore throat. Other symptoms may be considered at the discretion of the child's healthcare provider.

[2] Do not use this algorithm for testing newly symptomatic children and staff who have a *documented COVID-19 diagnosis in the last 90 days*; instead, test using a 2-antigen-test approach, in which 1 positive antigen test confirms a new diagnosis of COVID-19 and 2 negative antigen tests spaced apart by at least 48 hours rule out a new diagnosis of COVID-19.

[3] When a second rapid antigen test is used to confirm the results of an initial negative rapid antigen test, the second test should be administered at least *48 hours* after the first test. There is no spacing requirement for using NAAT/PCR or rapid molecular tests to confirm initial rapid antigen results.

[4] Consider non-COVID medical isolation if another communicable disease is suspected or confirmed. Children may be released to the general population of the facility or foster home if cleared of other communicable diseases by their healthcare provider. Staff may return to on-site work without restrictions.

[5] Children with COVID-19 should be isolated for 10 days from the date of symptom onset. Staff with COVID-19 should be excluded from on-site work until they meet criteria to discontinue isolation. Some children and staff may qualify for shortened isolation per ORR guidance. See *Field Guidance #6* for details.