



Interim Guidance for Child Care Programs

September 11, 2020

This guidance was developed by the San Francisco Department of Public Health (SFDPH) for local use. It will be posted at <http://www.sfgdcp.org/CovidSchoolsChildcare>. This guidance may change as new knowledge emerges and local community transmission changes.

Summary of Changes since the 9/1/2020 Version

Updated to align with [California Department of Public Health \(CDPH\) guidance on small cohorts/groups of children and youth](#) published on 9/4/2020.

- Cohorts may have up to 16 persons, counting both staff and children.
- Each cohort may have up to 4 staff, including trained volunteers and interns.
- Staff who work only with children 0-5 years old may work with two cohorts of children. However, they must work in exclusive “staff groups” of up to 4 staff, where people in a staff group work only with each other, and all staff in a group work with the same two cohorts of children.

AUDIENCE: Child care programs in San Francisco. For the purposes of this guidance, child care programs refers to all group care facilities for children who are not yet in elementary school. This includes child care centers; child development facilities; family child care homes; and preschools, transitional kindergarten, pre-kindergartens and kindergarten programs that are not part of an elementary school.

PURPOSE: To help child care programs understand health and safety practices needed to prevent spread of COVID-19 in their programs.

BACKGROUND: Child care programs in San Francisco were allowed to open for all children on June 1, 2020. Behaviors that prevent spread of COVID-19—staying 6 feet apart, wearing face coverings, and practicing good hygiene can be challenging for young children. Child care programs must adjust and layer COVID-19 interventions to minimize the risk of infection for staff and children, while meeting children’s developmental and socio-emotional needs.

The general principles and strategies outlined this guidance are based on the best science available at this time and the current degree of COVID-19 transmission in San Francisco.



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Key messages for child care programs

- **Address adult-to-adult transmission, and adults as sources of infection.** Most COVID-19 cases in childcare settings have occurred in staff, not children.

Although children can be infected with COVID-19 and can spread it to adults, this is less common than spread of infection between adults. Evidence to date indicates that children 0-9 years old are less likely to be infected and to infect others.

- **Preventing person-to-person transmission, via respiratory droplets, is more important than frequent cleaning and disinfection.** COVID-19 mainly spreads from person-to-person via respiratory droplets.
 - **Coronavirus cannot infect a person just by touching their skin. It must get into a person's nose, mouth or eyes to cause infection.** To get COVID-19 from touching a contaminated surface, a person must first touch the surface, and then touch their eyes, nose or mouth. Frequent handwashing breaks the chain of transmission.
 - **Coronavirus is easy to kill compared to norovirus.** Most household cleaning products are effective. Professional deep cleaning services are generally unnecessary.
- **The use of personal protective equipment (PPE) does not eliminate the need for physical distancing, portable barriers/partitions and universal face coverings.** PPE can give people a false sense of security. Physical distancing, barriers and face coverings are generally more important in preventing the spread of COVID-19 in childcare settings.
- **Exposure risk lies along a continuum.** A rule of thumb is that a person must spend at least 15 minutes within 6 feet of someone with COVID-19 to be at risk of infection.
 - Shorter interactions and interactions at greater distances are lower risk.
 - Smaller class sizes are better than larger, outdoor settings are better than indoor ones.
 - More people using face coverings is better than fewer people using face coverings.
 - Activities that produce fewer respiratory droplets are lower risk than those that produce many droplets (silence < quiet talking < loud talking < singing).
- **When working with young children, COVID-19 prevention needs to consider children's developmental and socio-emotional needs.** The benefits of early childhood education are well-known, and children are at low risk for severe COVID-19 and also low risk for rare but serious complications like multisystem inflammatory syndrome in children (MIS-C).
- **Any shift toward providing a more typical childcare experience should not put staff at greater risk.** Adult staff are at higher risk of severe COVID-19 than children. Recommendations for distancing and face coverings should prioritize staff safety and maximal protection of staff.



Prepare for re-opening

- Designate a COVID-19 staff liaison to be the single point of contact at each site for questions or concerns around practices, protocols, or potential exposure. This person will also serve as a liaison to SFDPH.
- Establish health and safety protocols to prevent COVID-19 transmission.
 - Train staff and teach children about health and safety practices.
 - Create a health and safety plan outlining what the program will do to implement the requirements in this guidance and any relevant Health Officer Directives or orders. Share this plan with staff, families, and other members of the childcare community.
- Work with SFDPH to support testing strategies to limit spread of COVID-19. This may include testing for staff or children, with parental consent.
- Establish protocols for staff and children with symptoms of COVID-19 and for communication with staff, children and families after COVID-19 exposure or a confirmed COVID-19 case in the facility.

Staff Considerations

- Protect staff, especially those at higher risk of severe COVID-19 illness. See [sfdcp.org/covid19hcp](https://www.sfdcp.org/covid19hcp) for a list of groups at higher risk for severe COVID-19.
 - Offer options that limit exposure risk to staff who are in groups at higher risk for severe COVID-19 illness (e.g., telework, reassignment, or modified job duties to minimize direct interaction with children and staff).
 - Staff at higher risk for severe COVID-19 illness should not be assigned to screen children for symptoms or monitor/care for sick children waiting to be picked up.
 - Consider the use of a portable plexiglass barrier or other barrier, or use a clear window for staff when screening for COVID-19 symptoms (persons entering the building, children who feel sick).
 - Consider the use of face shields, to be used with face masks or other cloth face coverings, for staff for additional protection. If supplies of face shields are limited, prioritize them for staff who are in groups at higher-risk of severe COVID-19 illness.
- Plan ahead for staff absences as community transmission of COVID-19 increases. Recruit people experienced caring for children, to ensure that you have a roster of substitute caregivers who can fill in. For more information, see SFDPH return-to-work guidelines at <https://www.sfdcp.org/rtw>.



Considerations for Children

- Prioritize enrollment of the following groups:
 - Children of people who work in businesses and organizations that are allowed to remain open or re-open under San Francisco Health Orders
 - At-risk children and youth, including:
 - Children and youth who are clients of Family and Children’s Services (FCS) or are at risk of abuse, neglect, or exploitation
 - Children eligible through the Emergency Childcare Bridge Program for Foster Children
 - Children and youth experiencing homelessness
 - Children of domestic violence survivors
 - Children and youth with disabilities or special health care needs whose individualized education programs (IEP) and/or individual family support plans (IFSP) include ELC services
 - Children and youth from low-income families, including those who receive or are eligible for free or reduced school lunch, Medi-Cal, SNAP (food stamps), WIC, Head Start, CalWorks and other public assistance programs.
- Do not exclude children because of medical conditions such as diabetes, asthma, leukemia and other malignancies, and autoimmune diseases that may put them at higher risk of severe COVID-19. Allow the child’s medical team and family to determine whether in-person attendance is safe.

Strategies to prevent spread of COVID-19 in child care settings

Screen everyone entering the building for COVID-19 symptoms or exposures.

- Ask all persons entering the childcare facility about symptoms of COVID-19 and exposure to COVID-19 – including staff, children, parents/caregivers, contractors, and visitors. Emergency personnel responding to a 9-1-1 call are exempt.
- Do not allow people who answer “yes” to any of the screening questions to enter the facility.
- Programs may also choose to require temperature checks of people entering the building, either on-site or done by parents at home. SFDPH does not require temperature checks.
 - Per CCLD/CDSS, only programs with a “non-touch” (infrared) thermometer should routinely check temperatures when children and/or staff arrive. SFDPH also recommends “non-touch” thermometers when checking temperatures of people entering a facility. Thermometers that touch the child (under the tongue or arm, forehead, etc.) should only be used when staff suspect fever or illness.
- For specific guidance on conducting symptom screening and temperature checks, see [COVID-19 Health Checks at Programs for Children and Youth](#) (children) and [Asking COVID-19 Screening Questions at Any Business, Organization or Facility](#) (adults)





Staff and children who are sick must stay home.

- Remind parents to keep children home when ill. A parent/guardian handout, “COVID-19 Health Checks/If Your Child has Symptoms” is available at <https://sfcdcp.org/covidschoolschildcare>.
- Implement sick leave policies that support childcare providers to stay home when ill.
- Encourage family members of children and staff to get tested promptly if they have symptoms of COVID-19, to lower the risk of spread to children or staff at the childcare.
- Encourage children and staff to stay home for 14 days after traveling out of the San Francisco Bay Area, if their activities during their trip put them at risk for COVID-19 infection. This does not apply to staff and children who regularly commute to childcare from places outside of the San Francisco Bay Area. Higher-risk activities include:
 - Spending time within 6 feet of people outside their household when not wearing face masks, especially if indoors.
 - Travel on planes, buses, trains, or other vehicles shared with people outside their household when face coverings were not worn at all times by all passengers.

Restrict non-essential visitors

- Limit non-essential visitors, including volunteers.
 - Therapists who are not childcare employees but work with children on-site at childcares, such as ABA therapists, occupational therapists and physical therapists, are considered essential staff and should be allowed to provide services.
- Discourage parents and other family members from entering the building.
- Redesign tours and open houses to meet guidelines for group size, screening, physical distancing, face coverings, hand hygiene, and cleaning and disinfection. Do not allow tours when children are present. Keep a log of all persons present.
- Cancel special events that involve parents and families, such as festivals, holiday events, and performances.



Keep staff and children in small, stable groups (“cohorts”).

A cohort is a stable group that has the same staff and children each day, stays together for all activities (e.g., lunch, recess, etc.), and avoids contact with people outside the group. Keeping childcare providers and children in the same small cohort each day lowers their exposure risk by limiting the number of people they interact with.

Limit cohort size

Type of Child Care	Maximum cohort size (Staff and Children)
Childcare Center	16
Family Childcare Home (FCCH)	16, or the maximum number of children allowed by the childcare’s license, whichever is lower.

- Up to 4 staff may work with a cohort, including trained volunteers. Follow state-required staff-child ratios.
- The maximum cohort size applies to everyone in the cohort, even if not they do not attend or work at the program at the same time. For example,
 - A cohort may not include 2 staff, 6 children who attend full-time, 6 children on Mon/Wed/Fri, and 6 children on Tu/Th (total of 20).
 - A cohort may not include 2 staff, 8 children who attend for the entire day, 4 who attend mornings only, and 4 who attend afternoons only (total of 18).
 - A cohort may not include 14 children, a teacher, one parent-volunteer on MWF, and a 2nd-parent volunteer on Tu/Th (total of 17).
- Newly enrolled children may join a cohort at any time, but they must enroll for a period of at least 3 weeks. Do not allow children to attend for shorter periods, for example, for a day or a week during school holidays.
- Staff who work with children over 5 years of age must be assigned to only one cohort and work only with that cohort. Staff may not work with more than one cohort of children or youth. For example,
 - Staff working with children over 5 may not work with one cohort on Mon/Wed/Fri, and another cohort on Tu/Th.
 - Staff working with children over 5 may not work with 1 cohort in the mornings, and another in the afternoons.



- Staff who work only with children 0-5 years of age may be assigned to two cohorts. Programs where staff work with two cohorts must place staff in groups of up to 4 staff members. Everyone in a staff group must work with the same two cohorts. Staff must work only with other staff in their staff group, and can only be in 1 staff group. For example:
 - Allowed: (3 staff members in a group working with 2 cohorts)
Staff A and B work with one cohort of children on Mon/Wed/Fri.
Staff B and C work with a different cohort of children on Tu/Th.
 - Not allowed (5 staff members working with 2 cohorts) :
Staff A, B and C work with one cohort of children on Mon/Wed/Fri.
Staff C, D and E work with another cohort of children on Tu/Th.
 - Not allowed: (4 staff members working with 3 cohorts)
Staff A and B work with cohort 1 on Mon/Wed/Fri.
Staff A and C work with cohort 2 on Tu/Th mornings.
Staff B and D work with cohort 3 on Tu/Th afternoons.
- Substitute providers who are covering for short-term staff absences are allowed, but must work with only one cohort of children per day.
- “Floaters,” who provide brief coverage for providers throughout the day, must work with only one cohort of children per day.
- When determining the number of staff in a cohort, do not count people who provide one-to-one services to individual children but do not interact with the entire cohort. This includes but is not limited to occupational therapists, physical therapists, speech and language therapists, and ABA providers. See the San Francisco Health Directive on Specialized Support Services for more information at <https://www.sfdph.org/dph/alerts/files/Directive-2020-26-Specialized-Support.pdf>
- Avoid changing staff assignments if possible.

Keep cohorts from mixing.

- Minimize interactions between cohorts, including interactions between staff assigned to different cohorts.
 - Assign children who live together or carpool together to the same cohort, if possible.
 - Keep cohorts separate for special activities such as art, music, and exercise. Stagger playground time and other activities so that no two cohorts are in the same place at the same time.
- Each cohort must be in a separate room or space.
- Avoid moving children from one cohort to another, unless needed for a child’s overall safety and wellness.



Partition large indoor spaces to prevent direct air flow between cohorts.

- A room divider or partition may be used to allow more than one cohort to use a large indoor space if the following requirements are met.
 - All cohorts are from the same childcare program.
 - Staff and children do not need to enter another cohort's space to access bathrooms, kitchens, other common areas or exits. If one cohort must pass through another cohort's space is required to pass through to another space, the time spent must be as brief as possible. It is preferable to use partitions to separate the pass-through space from both cohorts.
 - The room divider must prevent direct air flow between cohorts.
 - Best Practice: Solid, non-permeable, cleanable partitions extending to as close to the ceiling as practical to reduce direct and indirect air flow between cohorts.
 - Minimum Requirement: Solid non-permeable, cleanable partitions extending from the floor and at least 8 feet high.
 - The room divider must not:
 - Interfere with ventilation of each space (e.g. windows must be present on either side of the partition or, if mechanical ventilation is used, supply and return diffusers must be present on each side of the partitions), or
 - Obstruct sprinkler systems, access to emergency exits and other fire and building codes.
 - If smoke detectors are required and/or are in use in the building, separate smoke detectors may be required on each side of the room divider. Seek consultation as needed for each facility.

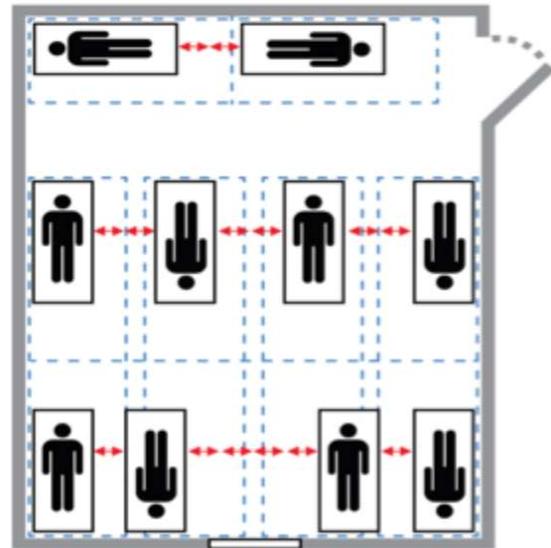
Physical distancing

Physical distancing decreases the risk of COVID-19 from respiratory droplets. Physical distancing between adults must be maintained as much as possible. Physical distancing between young children should be balanced with developmental and socio-emotional needs of this age group.

- Stay 6 feet from other adults, including staff in the same cohort, as much as possible.
 - Set up offices and staff rooms so that staff do not work or sit within 6 feet of each other.
 - Consider virtual meetings using video conferencing apps for parent-teacher meetings and staff meetings, even when all staff are present in the child care.
- Stay 6 feet away from children when and to the extent feasible.
- During individual activities, space children 6 feet apart when possible.
- During group activities, playtime and recess, physical distancing may be relaxed for children, especially if children are wearing face coverings or outside.
- Prioritize preventing interactions between cohorts over physical distancing within a cohort in shared spaces like play areas.



- Offer more opportunities for individual activities, such as painting or crafts. Choose group activities that do not involve close contact between children.
- Rearrange furniture and play spaces to prevent crowding and promote physical distancing between children who are not playing together.
- At naptime, place children's mats or cribs as far apart as possible, so that their heads are at least 6 feet apart. Have children lie on their mats so that they are head-to-toe (see diagram).
- Do not hold gatherings like sing-alongs, and other activities that bring different cohorts together, even if outdoors.



Face masks and cloth face coverings

Face masks and other cloth face coverings keep people from spreading the infection to others, by trapping respiratory droplets before they can travel through the air. In the childcare setting where physical distancing is often not practical, face coverings are the single most important measure to protect staff from COVID-19 infection

- All adults and children 10 years and older must wear face masks or cloth face coverings over both their nose and mouth at all times. This includes family members and caregivers dropping-off or picking-up children.
 - Staff, family, and visitors may not enter the building unless they are wearing a face covering or have documentation of a medical contraindication to face coverings. Keep a supply of face coverings for individuals who have forgotten to bring one.
 - Family members must wear face coverings when dropping-off or picking-up a child.
- Children 2-9 years old should wear face coverings as much as feasible when in public, per SF Health Order, for example, when walking to a nearby park or during drop-off or pick-up. Face coverings at drop-off are especially important to protect staff who are screening children for COVID-19 symptoms or checking temperatures.
- Children 2-9 years old should use face coverings as much as feasible during the following times:
 - During group activities or playtime when children are not physical distancing, especially indoors.
 - In situations where children may encounter staff and children from other cohorts, for example, at drop-off and pickup, and in hallways, bathrooms and outside play areas.
 - If a child becomes ill after arriving and is waiting for pick-up (and is not asleep)
- Reusable cloth face masks are recommended over disposable face masks, and can be sent home with families to be laundered.



- Children may remove face coverings when physically distanced, for example, when working at individual stations, or during vigorous physical activity outdoors. Face coverings must be removed for naps.
- Do not exclude children from childcare or use punitive measures if they will not wear a face covering. Continue to encourage and remind them to wear their face covering. A child who refuses to wear face coverings at home may be more willing to wear a face covering in a setting where all staff and other children are wearing them.

The widespread use of face coverings can significantly reduce the spread of infection, even if a few children are unable to wear face coverings. Consistent face covering use by adults is most important in preventing the spread of COVID-19, since most cases of COVID-19 in childcares so far have been adult staff who were infected in the community.

Exemptions to cloth face coverings; use of face shields

- Children 0-1 year old must not wear face coverings due to the risk of suffocation.
- Children with documented medical or behavioral contraindications to face coverings are exempt. This includes children who are unable to tolerate face coverings due to autism or sensory sensitivity, or children unable to independently remove face coverings due to developmental delay or disability.
- Staff with a medical contraindication documented by a medical provider to a face covering may be allowed to wear a face shield with a cloth drape on the bottom tucked into the top of their shirt. However, this is not as effective as a face covering in preventing spread of infection. Asthma, claustrophobia, and anxiety are not usually considered to be contraindications to face coverings.
www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/COVID-19/Guidance-for-Face-Coverings_06-18-2020.pdf
- Staff working with children who are hard-of-hearing may use a clear mask (a disposable or cloth face mask with a clear inset). If this is not feasible, a face shield with a cloth drape tucked into the shirt may also be used. Staff must wear a face covering at other times, for example, in staff-only areas.
- Do not use face shields in place of face coverings in other situations. Face shields have not been shown to keep the wearer from infecting others.
- Consider using a face shield in addition to a face mask or cloth face covering. Face shields provide additional eye protection for the wearer. When used with a mask or face covering, a cloth drape is not needed.



Hand hygiene

Frequent handwashing and hand sanitizer use removes COVID-19 germs from people's hands before they can infect themselves by touching their eyes, nose or mouth.

- Develop routines and schedules for staff and children to wash or sanitize their hands frequently, including:
 - Immediately after arriving,
 - Before and after eating,
 - Before naptime (*pay special attention to handwashing before and after naptime for children who suck their thumbs*),
 - After going to the bathroom or diapering, and
 - After wiping noses, coughing or sneezing.
- Post signs to remind staff and children of hand hygiene.
 - Hand hygiene signs for adults in multiple languages are at: <http://eziz.org/assets/docs/IMM-825.pdf>
 - Hand hygiene posters for children in multiple languages are at: <https://www.cdc.gov/handwashing/posters.html>
- Educate children and staff about basic measures to prevent the spread of infection, including covering one's coughs and sneezes and washing hands frequently.
- Keep hand sanitizer out of the reach of young children, and supervise use.
 - The California Department of Public Health (CDPH) does not recommend hand sanitizer for children under 24 months old.
 - Call Poison Control if hand sanitizer is consumed at 1-800-222-1222.

Ventilation and outdoor spaces

Increasing outdoor air circulation lowers the risk of infection by "diluting" any infectious respiratory droplets with outdoor air. Being outside is even lower risk.

- Do as many activities outside as possible, especially snacks/meals and activities that produce more respiratory droplets such as singing or active exercise.
 - Stagger use of outdoor spaces to keep cohorts from mixing. If the outdoor space is large enough, consider designating separate spaces for each cohort.
- Open windows to increase ventilation with outdoor air when health and safety allow, for example, when it does not worsen individuals' allergies or asthma. When possible to be done safely, consider leaving room doors slightly open to promote flow of outdoor air through the indoor space.
- Adjust mechanical ventilation systems to maximize fresh (outdoor) air ventilation. Minimize or eliminate return or recirculated air.
- For mechanical ventilation systems, increasing the intake of outdoor air and minimizing recirculated air should be prioritized over increasing filter efficiency during the COVID-19 pandemic.



Generally, opening windows and adjusting mechanical ventilation systems to maximize outdoor air intake will effectively increase the amount of outdoor air in a room. Although increased filter efficiency may be desirable for other reasons, such as improving indoor air quality near freeways or during wildfires, it is less important than maximizing outdoor air intake for COVID-19. Improving filter efficiency may require significant upgrades to the mechanical ventilation system. Portable air cleaners may be considered, but must be sized and positioned appropriately for the specific space.

Limit sharing

- Limit sharing of art supplies, manipulatives, and other high-touch materials as much as possible. If feasible, have a separate set of supplies for each child.
- Keep each child's supplies, belongings and bedding separate. Consider using individually labeled bins or cubbies.
- Limit use of shared playground equipment in favor of activities that have less contact with shared surfaces.
 - If used, outdoor play structures and natural play areas only need routine maintenance. Make sure the children wash or sanitize their hands before and after using these spaces. When hand hygiene is emphasized, cleaning and disinfection of outdoor play areas is not required between cohorts.

Cleaning and disinfection

COVID-19 is relatively easy to kill, and most household disinfectants are effective. Refer to [EPA's List N](#) for EPA-approved disinfectants effective against COVID-19.

- Clean and disinfect frequently touched surfaces, toys and other objects. Toys that may be put in a child's mouth should be cleaned and sanitized.
- Have multiple toys and manipulatives accessible that are easy to clean and disinfect throughout the day or provide individually labeled bins of toys for each child. Remove toys that are difficult to clean (e.g. soft toys, "loveys"), or make sure that they are used only by individual children and not shared.
- Designate a container for toys that need to be cleaned, sanitized, or disinfected before being introduced back into the childcare environment.
- For detailed instructions, see <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/guidance-for-child-care.html#CleanDisinfect>

Routine cleaning versus "deep cleaning" for COVID-19

The term "deep cleaning" can be misleading, and the CDC does not use the term.

- Routine cleaning focuses on frequently touched surfaces like door handles, desks, countertops, phones, keyboards, light switches, handles, toilets and faucets.
- Cleaning after a suspected or known case of COVID-19 **uses the same cleaning agents and disinfectants** as for routine cleaning, but includes the following steps:



- Open windows and use fans to increase outdoor air circulation in the areas to be cleaned.
- Wait 24 hours, or as long as practical, before cleaning and disinfection. CDPH recommends waiting at least 1 hour.¹
- Clean and disinfect all surfaces in the areas used by the ill person, including electronic equipment. Vacuum the space if needed.
- For details about cleaning after a suspected or known COVID-19 case, refer to CDC guidelines on “Cleaning and Disinfecting Your Facility” at <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html> and CDC guidelines for cleaning community facilities at <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html#Cleaning>

Specific Situations

Drop-off and pick-up

Limit staff contact with families at drop-off and pick-up

Require family members and caregivers to wear face masks or cloth face coverings when dropping off or picking up children, and at all times inside the childcare facility.

Staff should stay 6 feet away from parents and caregivers.

Stagger arrival and drop-off times to limit contact between families, if possible.

Consider curbside drop-off and pick-up, where staff come outside the facility to pick up the children as they arrive, and bring children outside to be picked up.

- Mark spaces 6 feet apart for children waiting to be screened at drop-off and for adults waiting to pick up children.
- Face coverings are required for adults who are dropping off or picking up children. Provide face coverings for family members who have forgotten theirs.
- Post signs to remind family members to stay 6 feet away from people from other households when dropping off or picking up their child.

¹ CDPH Outpatient Healthcare Facility Infection Control Recommendations for Suspect COVID-19 Patients <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/OutpatientHealthcareFacilityInfectionControlRecommendationsforSuspectCOVID19Patients.aspx>



Caring for infants and toddlers

Washing, Feeding, or Holding a Young Child

Washing, feeding or holding a child increases the risk of COVID-19 via respiratory droplets because of the close distance, especially if the child is crying. Skin contact with tears, mucus, and other secretions is much lower risk than the risk of breathing in respiratory droplets at such a close distance.

- Before holding a child aged 2 or over, the child should ideally be wearing a face covering over their mouth and nose, except when feeding. Consider wearing a face shield in addition to a face covering for added protection.
- Crying, sad and/or anxious infants and toddlers often need to be held and physically comforted. If the child is crying loudly, try to position the child so that they are not directly facing you (sitting sideways in a lap, for example, or standing slightly behind the child while rubbing their back). Try to keep your face away from child's face while holding or physically comforting them. Consider taking the child outside to comfort them.
- Consider covering your regular clothes with a smock or large shirt to keep tears, mucus, saliva or secretions from touching your clothing. For details of handling clothes with tears, mucus and other secretions, see <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/guidance-for-child-care.html#InfantsToddlers>.
- Wash your hands, as well as any skin that a child's tears, mucus or other secretions has touched, as soon as possible.

Diapering

Although the virus that causes COVID-19 has been detected in stool, there is no known transmission through touching stool or diapering. However, norovirus and a number of other infections can be spread through stool.

- Follow the usual safe diapering procedures, including handwashing before and after, and wear gloves. For detailed information, see <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/guidance-for-child-care.html#InfantsToddlers>

Meals and snacks

Eating together is especially high risk for COVID-19 transmission because people must remove their face coverings to eat and drink. Children often eat with their hands, and both children and adults often touch their mouths with their hands while eating. In addition, meals are usually considered time for talking together, which further increases risk, especially if children must speak loudly to be heard.

- Try not to eat with other staff, especially indoors. This is a common way that staff are exposed to COVID-19 at work.
- Eating outdoors is safer than eating indoors. Outdoor eating areas may be covered (e.g. with an awning), as long as no more than one side is closed, allowing sufficient air movement.
- Use individually plated or bagged meals instead of family-style meals.



- Consider staggering snack and lunch times so more people can eat outdoors without mixing cohorts.
- Space children as far apart as possible when eating, and try to seat them so they do not sit face-to-face. Physical distancing is especially important when eating, since face coverings cannot be worn.
- Make sure that children and staff wash their hands or use hand sanitizer immediately before and after eating. Pay special attention to children who like to suck/lick food off their hands.
- Consider starting lunch with silent eating time, followed by conversation time, to discourage talking while face coverings are off.
- Stay 6 feet away from children when their face coverings are off as much as possible, especially when eating indoors.
- Clean and disinfect tables and chairs between different cohorts. If eating outdoors, sidewalks and asphalt do not have to be disinfected.

Staff spaces: offices, break rooms and work rooms

Staff often do not view themselves and colleagues as sources of infection, and forget to take precautions with co-workers, especially during social interactions such as breaks or lunch time.

- Post the maximum occupancy for break rooms and other staff spaces, based on 6 foot distancing. If needed, mark places on the floor 6 feet apart for staff to sit or stand.
- Post signage reminding staff to stay 6 feet apart, keep their face coverings on unless eating, wash their hands before and after eating, and disinfect their area after using it.
- Consider creating a private outdoor area for staff to eat and take breaks.
- Open windows and doors to maximize ventilation in staff spaces.

Other activities to avoid: group singing, field trips and toothbrushing

- Avoid group singing, especially indoors.
- Field trips are currently prohibited
- Discontinue brushing teeth at childcares.



What to do when someone has suspected or confirmed COVID-19

Refer to *“When someone has suspected or confirmed COVID-19: Quick Guide for Schools, Childcares, and Programs for Children and Youth”* at <https://sfcdcp.org/CovidSchoolsChildcare> for the following summary charts:

- Steps to take when staff or children have COVID-19 symptoms, have been exposed (for example, a parent or sibling has tested positive), or have confirmed COVID-19.
- Returning to childcare after COVID-19 symptoms, close contact, or confirmed COVID-19.

When a child or staff member has symptoms of COVID-19

- Staff who develop symptoms at work must notify their supervisor and leave work as soon as feasible. For SFDPH guidance on when staff may return to work, see <https://sfcdcp.org/rtw>.
- Keep ill children in a separate area, away from other children, until they can be picked up.
- When a parent or guardian arrives, consider walking the child outside to meet them instead of allowing the parent or guardian into the building. Since children with COVID-19 are infected by a parent or other adult in their home, the parent may also have COVID-19.
- Open windows in areas used by the sick person to maximize outdoor air circulation. Close off those areas as soon as feasible, until they can be cleaned and disinfected.
- Children with symptoms may return to childcare when they have met the criteria in *“When Someone Has Suspected or Confirmed COVID-19: Quick Guide for Schools, Childcares, and Programs for Children and Youth.”* A parent handout, *“For Parents and Guardians: COVID-19 Health Checks for Children and Youth/If Your Child Has Symptoms”* is also available. Both documents are at <http://sfcdcp.org/CovidSchoolsChildcare>.

When a child or staff member has a positive COVID-19 test

- **Contact the SFDPH Schools and Childcare Hub** for consultation and guidance at **(415) -554-2830 Press 1 for COVID-19, then press 6 for Schools**
Schools-childcaresites@sfdph.org
- **Work with SFDPH to identify staff, children and other people in the childcare who had close contact** with the person with COVID-19. Individuals who had close contact should be notified, know how to get tested, and understand when they or their child can return to the program, usually 14 days after their last exposure. Consult SFDPH about closing the facility if when there are cases in more than one cohort, or for family child care homes, if someone in the home has COVID-19 and must remain in the home.
- **Close the areas used by the person with COVID-19 until they can be cleaned and disinfected.**
- **Communicate with staff and families.**
Maintain the confidentiality of the child or adult with COVID-19 as required by the Americans with Disabilities Act, the Family Education Rights and Privacy Act, and possibly HIPAA.



Resources

San Francisco Department of Public Health (SFDPH)

- **SFDPH Schools and Childcare Hub** for COVID-19 consultation and guidance (415) 554-2830. Press 1 for COVID-19, then press 6 for Schools
Schools-childcaresites@sfdph.org
- COVID-19 guidance for the public, including schools and employers
<https://www.sfdcp.org/covid19>
- *"Parent and Caregiver Handout: COVID-19 Health Checks/If Your Child has Symptoms."* Instructions for parents on health screenings and return to school guidelines if their child has COVID-19 symptoms, at <http://sfdcp.org/covidschoolschildcare>
- Outreach Toolkit for Coronavirus. Posters and flyers on physical distancing, hand hygiene, face masks, health screenings, getting tested, and other COVID-19 topics at <https://sf.gov/outreach-toolkit-coronavirus-covid-19>
- *"What to do if someone at the Workplace Tested Positive for COVID-19"*
<https://www.sfdcp.org/covid19> under Businesses and Employers.
- *"Leaving Isolation or Returning to Work for Those Who Have Confirmed or Suspected COVID-19"*
<https://www.sfdcp.org/rtw>

California Department of Public Health (CDPH)

- *"COVID-19 Update Guidance: Child Care Programs and Providers" 7/17/2020:*
<https://files.covid19.ca.gov/pdf/guidance-childcare--en.pdf>
- *"Guidance for Small Cohorts/Groups of Children and Youth"*
<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/small-groups-child-youth.aspx>
- *"COVID-19 Case and Contact Management Within Child Care Facilities"*
<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/contact-management-childcare-facilities.aspx>

Centers for Disease Control and Prevention (CDC)

- Guidance for Schools and Childcare
<https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/index.html>
- Guidance for Child Care Programs that Remain Open
<https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/guidance-for-childcare.html>
- Cleaning and Disinfection for Community Facilities
<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html>