



MASSACHUSETTS  
Department of  
Early Education and Care

# MASSACHUSETTS CHILD AND YOUTH SERVING PROGRAMS REOPEN APPROACH

## Minimum Requirements for Health and Safety

May 28, 2020



Developed in partnership with the Department of Early Education and Care (EEC), Executive Office of Health and Human Services (EOHHS), Department of Public Health (DPH), Department for Children and Families (DCF), and Department of Elementary and Secondary Education (DESE).



## Background and Document Purpose

On March 10, 2020, Governor Charlie Baker declared a State of Emergency in the Commonwealth in response to the COVID-19 pandemic (Executive Order No. 591: Declaration of a State of Emergency to Respond to COVID-19). Subsequent orders called for extended K-12 school closures and the suspension of non-emergency child care programs. On March 18, 2020, the Department of Early Education and Care (EEC) made Exempt Emergency Child Care Programs (EECCP) available, with [priority access](#) for vulnerable children and the families of essential workers, with an emphasis on those in health care, public health, human services, law enforcement, public safety, and first responder fields. The EECCP will continue to operate until further notice. On May 18, 2020, the Baker-Polito Administration announced [Reopening Massachusetts](#), a comprehensive phased plan to safely reopen the Massachusetts economy, get people back to work, and ease social restrictions while minimizing the health impacts of COVID-19.

Child care and youth-serving programs are a critical component in getting the Commonwealth back to work. To prepare for reopening, the EEC assembled a Health and Safety Working Group with members representing the Executive Office of Health and Human Services (EOHHS), Department for Children and Families (DCF), Department of Elementary and Secondary Education (DESE), and Department of Public Health (DPH). The Health and Safety Working Group has established the Massachusetts Child and Youth Serving Programs Reopen Approach: *Minimum Requirements for Health and Safety* for child care programs, recreational camps, and municipal or recreational youth programs not traditionally licensed as camps that are seeking to operate during the phased plan of Reopening Massachusetts.

In developing these requirements, the Health and Safety Working Group has sought to keep the health and safety of the Commonwealth's children and program staff at the forefront. The Working Group has sought to build upon existing guidance from leading health experts, including the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics. Additionally, these requirements have been reviewed by medical experts at Boston Children's Hospital. Unless specifically noted, these requirements apply to all child and youth-serving programs. EEC looks forward to engaging extensively and collaboratively with program staff and others to receive feedback, insights, and guidance to ensure supports are in place for programs and providers to meet the *Minimum Requirements for Health and Safety*. In addition, the Working Group anticipates developing supplementary materials (e.g., sample templates, frequently asked questions) to complement these requirements and provide support through all phases of reopening..

The Commonwealth recognizes that COVID-19 has presented significant, unexpected challenges for the child and youth-serving program community. Further, EEC understands that it may be challenging for child care programs to meet the requirements for reopening in the earlier phases and is cognizant that some programs may have to remain temporarily closed as a result. EEC is also aware that the proposed requirements may present particular challenges for family child care providers and is continuing to consider ways to support these critical providers as they prepare to reopen. On behalf of the Baker-Polito Administration and its interagency partners, EEC thanks the field for their continued dedication, partnership, and patience as we all work together to reopen safely while protecting the health and welfare of all children, families, and staff.

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## Definitions

**Center-Based Care** – Child care provided in a non-residential setting.

**Clean** – Cleaning removes germs, dirt, and impurities from surfaces or objects. Cleaning works by using soap (or detergent) and water to physically remove germs from surfaces. This process does not necessarily kill germs, but by removing them, it lowers their numbers and the risk of spreading infection.

**Communicable Disease** – A disease that is spread from one person to another in a variety of ways, including travel through the air, contact with bodily fluids, contact with a contaminated surface, object, food or water, and certain animal or insect bites.

**Coronavirus** – Any of a family (Coronaviridae) of large single-stranded RNA viruses that have a lipid envelope studded with club-shaped spike proteins, infect birds and many mammals including humans, and include the causative agents of MERS, SARS, and COVID-19.

**COVID-19** – A mild to severe respiratory illness that is caused by a coronavirus (severe acute respiratory syndrome coronavirus 2 of the genus betacoronavirus), is transmitted chiefly by contact with infectious material (such as respiratory droplets) or with objects or surfaces contaminated by the causative virus, and is characterized especially by fever, cough, and shortness of breath and may progress to pneumonia and respiratory failure.

**DESE** – The Massachusetts Department of Elementary and Secondary Education.

**Disinfect** – Disinfecting kills germs on surfaces or objects. Disinfecting works by using chemicals to kill germs on surfaces or objects. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs on a surface after cleaning, it can further lower the risk of spreading infection. Disinfecting may be appropriate for diaper tables, door and cabinet handles, toilets, and other bathroom surfaces. Changing tables should be *cleaned and then disinfected after each use*.

**DPH** – The Massachusetts Department of Public Health.

**EEC** – The Massachusetts Department of Early Education and Care.

**Exposed** – Having had close contact with someone symptomatic of COVID-19 from the period of 48 hours before symptom onset until 10 days from when they first had symptoms.

**Fever** – A measured or reported temperature of  $\geq 100.0^{\circ}$  F.

**Group** – Two or more children who participate in the same activities at the same time and are assigned to the same educator for supervision, at the same time.

**Health Care Consultant** – A Massachusetts licensed physician, registered nurse, nurse practitioner, or physician's assistant with pediatric or family health training and/or experience.

**Health Care Practitioner** – A physician, physician's assistant or nurse practitioner.

**Health Care Supervisor** – A person on the staff of a recreational camp for children who is 18 years of age or older and who is responsible for the day to day operation of the health program or component. The Health Care Supervisor shall be a Massachusetts licensed physician, physician assistant, certified nurse practitioner, registered nurse, licensed practical nurse, or other person specially trained in first aid.

**Family Child Care** – Child care provided in a professional caregiver's home.

**Fixed Age Group** – A group of children within the same age range, such as infants, toddlers, preschoolers, kindergarteners, and school age children.

**Infant** – A child who is younger than 15 months old.

**Kindergarten Child** – A child who is five years old or who will attend first grade the following academic year in a public or private school.

**Multi-Age Group** – A group of children from birth through 13 years (or 16 years, if such children have special needs) assigned to a single group. Multi-age groups may include no more than three children younger than two years old, including at least one toddler who is walking independently. Additional children must be older than 24 months.

**Parent** – Father or mother, guardian, or person or agency legally authorized to act on behalf of the children in place of, or in conjunction with, the father, mother, or guardian.

**Personal Protective Equipment (PPE)** – PPE is used to minimize exposure to hazards that cause serious illness or injury. Gloves, masks, and gowns are all examples of PPE.

**Premises** – The facility or private residence that is used for the child or youth serving summer program and the outdoor space on which the facility or private residence is located.

**Preschooler/Preschool Child** – Any child that is at least two years and nine months old (33 months of age), but not yet attending kindergarten.

**Program** – An organization or individual that provides early education and care services to children or youth. Programs may include family child care, center-based child care, school age child care, recreational day camps and municipal or recreational youth programs not traditionally licensed as camps.

**Program Staff** – All individuals working with children and/or youth in early education and care or summer camp programs, including municipal or recreational youth programs not traditionally licensed as camps. Staff may include directors, administrators, family child care providers, approved assistants, group leaders, camp counselors, nurses, educators, and other individuals employed by the child or youth serving program who may have contact with children.

**Recreational Camp** - A program that is required to be licensed as a Recreational Camp for Children under 105 CMR 430.000.

**Recreational Program** - Municipal or recreational youth programs not traditionally licensed as camps or as child care facilities.

**Sanitize** – Sanitizing lowers the number of germs on surfaces or objects to a safe level, as judged by public health standards or requirements. This process works by cleaning and then sanitizing surfaces or objects to lower the risk of spreading infection. Surfaces used for eating and objects intended for the mouth (food service tables and highchair trays, pacifiers, mouthed toys, etc.) must be *cleaned and then sanitized both before and after each use*.

**School Age Child** – A child age 6 or older who is attending a public or approved private elementary school. The upper age limit for each program shall be consistent with the regulations currently set by each regulatory agency or body.<sup>1</sup>

**Toddler** – A child who is at least 15 months of age, but younger than 33 months of age.

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<sup>1</sup> EEC regulated child care programs can serve youth up to age 14, or age 16 for children with special needs. DPH regulated camp programs can serve youth up to age 18 as campers.

## Minimum Requirements for Health and Safety

The following requirements apply to all child and youth-serving programs, including recreational summer programs, recreational summer camps for children, municipal or recreational youth programs not traditionally licensed as camps, family child care, and center-based child care. Specific requirements for recreational camps and recreational programs only are included in Section 13. In addition to these requirements, it is recommended that programs frequently check the [CDC website](#) to ensure they are implementing the most current CDC guidance. These minimum requirements may be amended as the Commonwealth's COVID-19 status evolves over time and public health experts learn more about the virus.

The Commonwealth recognizes that it will be very challenging for programs to reopen, given the significant requirements and federal and state mandates. While we recognize that the requirements place additional burdens on many programs, the following requirements must be implemented in order to protect the health and safety of all children, families, and staff. Programs that are unable to adhere to the following requirements must remain closed and reopen at a later date.

### 1. Preparedness and Planning

- A. **Planning:** Programs must develop plans prior to reopening (and maintain them once reopened) to address how they will meet the new health and safety requirements. Programs must identify all the ways reopening during the COVID-19 pandemic might affect the program and develop a plan of action. Elements of this planning **must** include the following:
- (1) A cleaning plan that identifies what items must be cleaned, sanitized, or disinfected and with what frequency. This must include a daily cleaning schedule for staff (before, during, and after programming) to ensure that all areas, materials, furniture, and equipment used for child care are properly cleaned, sanitized, or disinfected. Programs must also have a plan in place to obtain and maintain inventory of essential cleaning supplies.
  - (2) A plan for identifying and handling sick, symptomatic, and exposed children and staff that includes but is not limited to daily screening checks, location of screening activities, staff responsible for screening, and barriers for screening.
  - (3) A plan for the isolation and discharge of sick, symptomatic, and exposed children or staff, including procedures for contacting parents immediately, criteria for seeking medical assistance, transportation of children or staff who have developed symptoms related to COVID-19 mid-day and who rely on program transportation, and mitigation of transmission until a sick individual can safely leave the program.
  - (4) A plan to work with their local and state health departments to ensure appropriate local protocols and guidelines are followed, such as updated/additional guidance for cleaning and disinfection and instructions and availability of COVID-19 testing.
  - (5) A plan for safe vendor deliveries, if applicable. Non-contact delivery protocols must be arranged whenever possible.
  - (6) A plan for transportation that includes how to implement infection control strategies during transportation, including during boarding and disembarking, and a plan to maintain physical distancing and hand hygiene practices.
  - (7) A plan for handling program closings, staff absences, and gaps in child attendance. The plan must include procedures to alert local health officials about large increases in child and staff absences or substantial increases in respiratory illnesses (like the common cold or the "flu," which have symptoms similar to symptoms of COVID-19). Programs must determine how the facility will communicate with staff and parents and identify who will be responsible to inform the funding agency, local board of health, and other appropriate audiences.

- (8) A plan for the administration of medication including a plan for the treatment of children with asthma and other chronic illness. Nebulizer use must be prohibited as it can increase risk of the virus being aerosolized.
  - (9) A plan for coordinating space and facilitate support services for children, including when identified on an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). A space should be made available to allow for service delivery to occur, whenever possible.
  - (10) A plan for sharing information and guidelines with parents that includes the following:
    - (a) A system to check with parents daily on the status of their children when children are dropped off at the facility.
    - (b) Ensuring information and communication can be provided in the primary languages spoken by the parents.
    - (c) Obtaining email addresses and home, work, and mobile phone numbers from parents of children at the program so that the program can reach them at any time.
    - (d) Creating and testing communication systems with parents, children at the program, all staff, facility and/or grounds management, and emergency medical services.
    - (e) Providing parents with information on COVID-19 including symptoms, transmission, prevention, and when to seek medical attention. Encouraging parents to share the information with their children as appropriate.
    - (f) Providing parents with guidance on how to share information with their children in developmentally appropriate ways and encouraging parents to share the information with their children, as appropriate.
    - (g) Providing parents with information on the program's policies for preventing and responding to infection and illness.
    - (h) Identifying a person responsible for sharing information to parents if and when an exposure occurs, and how that information will be communicated.
- B. Preparing: Programs must prepare the program environment to promote the new health and safety requirements and to facilitate infection control activities.
- (1) Prepare the materials and equipment to be used by children to minimize sharing and promote distancing. Remove items that cannot be easily washed (e.g., stuffed animals, pillows) or that encourage children to put the toy in their mouths (e.g., play food, pretend utensils). If programs allow children to bring in items from home, they should have a plan in place to ensure the cleanliness of these items and should carefully monitor use to ensure that these objects are not shared between children. Shared items that cannot be cleaned or disinfected at all (e.g., playdough) must be removed from activity rotation. Remove all water, sand, and sensory tables and activities.
  - (2) Prepare all cleaning, sanitizing, and disinfecting solutions and identify a safe place for storage that is accessible to staff in each area of the program, but out of reach of children. Ensure that supplies for hand hygiene are adequate and placed appropriately throughout the program space, including in all group, transition (e.g., hallways), and common spaces.
  - (3) Prepare the program space to promote physical distancing. Programs must consider the physical building capacity limitations and the total number of children anticipated to be in any one area. Decisions about organization of the program space must be guided by the program's ability to implement adequate and consistent physical distancing, especially in terms of utilization of common spaces that need to be shared by all children. Areas occupied by individual groups must be defined by permanent walls, movable walls, or other partitions. Programs with large spaces must consider using barriers to create clearly defined and separate areas for small groups of children. Program staff must

review the physical distancing requirements for children in the program and be prepared to support children with adjustment to new systems and routines.

- (4) Ensure that there are adequate provisions for the storage of child and staff belongings so that they do not touch.
- (5) Close drinking fountains that require contact for use. Motion activated or touchless drinking fountains are acceptable for use only when filling cups, water bottles, or other receptacles.
- (6) Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible by opening windows and doors, using fans (must be inaccessible to young children), and other methods. Do not open windows and doors if doing so poses a safety or health risk (e.g., allows pollen in or exacerbates asthma symptoms) to children using the facility. In rooms located above the first floor, windows must be either inaccessible to children or protected with a window guard.
- (7) Take steps to ensure that all water systems and features (e.g., decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

## 2. Staffing and Operations

### A. Daily Operations: Programs must make the following changes to their operations.

- (1) Cancel all field trips, inter-group events, and extracurricular activities.
- (2) Avoid holding activities involving multiple groups attending at the same time and strictly enforce the restrictions on non-essential visitors.<sup>2</sup> This includes parent volunteers, coaches and consultants. Non-essential adults must be prevented from entering the premises.<sup>3</sup>
- (3) For each child enrolled, programs must maintain on file a physician's, nurse practitioner's, or physician's assistant's certification that the child has been successfully immunized in accordance with the current DPH's recommended schedules.
- (4) For each child with a chronic medical condition that has been diagnosed by a licensed Health Care Practitioner, programs must maintain an individual health care plan (IHCP). The plan shall describe the chronic condition, its symptoms, any medical treatment that may be necessary while the child is in care, the potential side effects of that treatment, and the potential consequences to the child's health if the treatment is not administered.

### B. Staffing: All programs must meet the following staffing requirements to respond to the COVID-19 crisis.

- (1) Programs must meet all staffing requirements per the authorizing entity for their specific program type.<sup>4</sup> Staffing requirements for child and youth-serving summer programs may be relaxed for reopening under the authority of the authorizing entity.
- (2) Provide staff with information about COVID-19, including how the illness is spread, how to prevent its spread, symptoms, and when to seek medical assistance for sick children or employees.
- (3) Have a system to monitor absenteeism to identify any trends in employee or child absences due to illness, as this might indicate spread of COVID-19 or other illness.
- (4) Have a plan for securing trained back-up staff in order to maintain sufficient staffing levels.

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<sup>2</sup> Non-essential visitors will be defined by each agency in a separate policy.

<sup>3</sup> This applies to family child care programs, with the understanding that family members will be present in the home. Family child care programs should limit household members' presence in the same spaces used for child care.

<sup>4</sup> This includes assistants in family child care programs where the staff-to-child ratio requires more than 1 adult.



- (5) Ensure that their sick leave policies are flexible and promote the importance of staff not coming to work if they have a frequent cough, sneezing, fever, difficulty breathing, chills, muscle pain, headache, sore throat, or recent loss of taste or smell, or if they or someone they live with has been diagnosed with COVID-19.
- (6) Designate a staff member to be responsible for responding to COVID-19 concerns. Employees must know who this person is and how to contact them.
- (7) Create a communication system for staff and families for self-reporting of symptoms and notification of exposures and closures.
- (8) Encourage all staff age 65 or older or with serious underlying health conditions to talk to their healthcare provider to assess their risk and to determine if they must stay home or follow additional precautions.
- (9) Train staff in all areas to ensure protocols are implemented safely and effectively in all programs.
- (10) Develop policies for worker protection and provide training to all cleaning staff on site prior to providing cleaning tasks. Training must include when to use PPE, what PPE is necessary, how to properly put on, use, and take off PPE, and how to properly dispose of PPE.
- (11) Ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with Occupational Safety Hazard Administration (OSHA)'s Hazard Communication standard (29 CFR 1910.1200).
- (12) Educate staff and workers performing cleaning, laundry, and trash pick-up activities to recognize the symptoms of COVID-19 and provide instructions on what to do if they develop symptoms. At a minimum, any staff must immediately notify their supervisor and the local health department if they develop symptoms of COVID-19. The health department will provide guidance on what actions need to be taken.

### 3. Group Sizes and Ratios

- A. **Group Sizes:** Group sizes must be restricted to a maximum of 10 children, with a maximum of 12 individuals including children and staff in each room. Guidance to maintain these group sizes includes the following:
  - (1) Children must remain with the same group each day and at all times while in care.
    - (a) When suitable to children's ages and developmental level, siblings in attendance at the same time must be kept in the same group.
    - (b) Groups must not be combined at any time.
  - (2) The same staff must be assigned to the same group of children each day for the duration of the program session (if weekly or monthly) and at all times while in care. Staff must not float between groups either during the day or from day-to-day, unless needed to provide supervision of specialized activities such as swimming, boating, archery, firearms, etc.
- B. **Required Ratios and Maximum Group Sizes:** In order to provide the level of supervision required to adhere to the following health and safety requirements, the following child-to-staff ratios must be maintained at all times during the program day. Guidance for ratios and group sizes for care of children with special needs are included in Section 12.

Age	Staff to Child Ratio	Maximum Group Size (Children)	Maximum Group Size (Children & Staff)
Infant <i>Birth – 14 months</i>	1:3 2:7	7	9

Toddler <i>15 – 32 months</i>	1:4 2:9	9	11
Preschool <i>≥33 months, but not yet attending Kindergarten</i>	2:10	10	12
Kindergarten <i>Attending Kindergarten</i>	1:10	10	11
School Age* <i>Attending First Grade +</i>	1:10	10	11
Family Child Care and Multi-Age** <i>All Age Groups</i>	1:6 2:8	8	10

**\*Please see the definition of School Age in the definition section to see upper age limits for programming.**

**\*\* Multi-age groups may include no more than three children younger than two years old, including at least one toddler who is walking independently. Additional children must be older than 24 months. Please see the definition of School Age in the definition section to see upper age limits for programming.**

#### 4. Screening and Monitoring of Children and Staff

A. Daily Screening: Programs must screen all staff and children before they are permitted to enter the child care space following the requirements below.

- (1) Establish a single point of entry to the program to ensure that no individual is allowed to enter the building until they successfully pass the screening.
- (2) Designate specific program staff to conduct all screening activities and thermometer checks, and establish a designated screening area (e.g., a side room or enclosed area close to the point of entry) that will allow for more privacy in order to ask questions confidentially or conduct a temperature check. Unless a physical barrier, such as a plexiglass screen, is used, the space used for screening must allow for social distancing of childcare staff from child/family while screening is being conducted (i.e. at least 6 feet of separation).
- (3) Health check responses and individual temperature check results must be recorded and maintained on file.
- (4) Verbally screen children and parents asking the following questions. If any of the below are yes, the child must not be allowed to enter the building. The child must return home with their parent or caregiver.
  - (a) Today or in the past 24 hours, have you or any household members had any of the following symptoms?
    - Fever (temperature of 100.0°F or above), felt feverish, or had chills?
    - Cough?
    - Sore throat?
    - Difficulty breathing?

- Gastrointestinal symptoms (diarrhea, nausea, vomiting)?
  - Abdominal pain?
  - Unexplained Rash?
  - Fatigue?
  - Headache?
  - New loss of smell/taste?
  - New muscle aches?
  - Any other signs of illness?
- (b) In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus (COVID-19)?<sup>5</sup>
- (5) Staff must make a visual inspection of each child for signs of illness, which could include flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness. Confirm that the child is not experiencing coughing or shortness of breath. In the event a child is experiencing shortness of breath or extreme difficulty breathing, call emergency medical services immediately.
- (6) Programs must include non-contact temperature checks (using a scanning or temporal thermometer), conducted by designated staff, as part of their screening protocols. To ensure that staff conducting temperature checks are able to do so safely, the following protocol must be followed:
- (a) Perform hand hygiene.
  - (b) If social distancing or barrier/partition controls cannot be implemented during screening, personal protective equipment (PPE) including eye protection (goggles or disposable face shield) that fully covers the front and sides of the face, in addition to mask and gloves, should be used when within 6 feet of a child. However, reliance on PPE alone is a less effective control than maintaining social distancing during screening.
  - (c) Check individual's temperature using a non-contact or temporal thermometer. **If performing a temperature check on multiple individuals, ensure that a clean pair of gloves is used for each individual and that the thermometer has been thoroughly cleaned in between each check, in accordance with [CDC recommendations](#) for infection control.**
  - (d) Remove and discard gloves and other PPE, in accordance with [CDC guidance](#). To reduce the risks of contamination when using PPE, staff must be adequately trained on appropriate donning and doffing of required PPE. Programs must have adequate space to safely don/doff PPE, designated space for clean PPE supply that is separate from dirty/contaminated/disposed PPE, and consideration should be given for ongoing shortages and unreliable supply of PPE nationally.
- (7) All staff, parents, children, and any individuals seeking entry into the program space must be directed to self-screen at home, prior to coming to the program for the day. If the program is a family child care program, all household members must self-screen before coming into the child care space.
- (a) Self-screening shall include checking temperature (temperature of 100.0°F or above is considered a fever), and checking for symptoms included fever, cough, shortness of breath, gastrointestinal symptoms, abdominal pain, unexplained rash, new loss of

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<sup>5</sup> Close contact is defined as being within 6 feet of an individual who has tested positive for COVID-19 for more than 10 minutes while that person was symptomatic, starting 48 hours before their symptoms began until their isolation period ends.

taste/smell, muscle aches, or any other symptoms that feel like a cold. Anyone with a fever of 100.0°F or above or any other signs of illness must not be permitted to enter the program.

- (b) Parents and staff must sign written attestations daily regarding any household contacts with COVID-19, symptoms (e.g., fever, sore throat, cough, shortness of breath, loss of smell or taste, or diarrhea), or if they have given children medicine to lower a fever.
  - (c) Individuals who decline to complete the screening questionnaire or have temperature checked will not be permitted to enter the program space.
- B. **Regular Monitoring:** Staff must actively monitor children throughout the day for symptoms of any kind, including fever, cough, shortness of breath, diarrhea, nausea, and vomiting, abdominal pain, and unexplained rash. Children who appear ill or are exhibiting signs of illness must be separated from the larger group and isolated until able to leave the facility. Programs must have a non-contact or temporal thermometer on site to check temperatures if a child is suspected of having a fever (temperature above 100°F). Special care must be taken to disinfect the thermometer after each use.
- (1) If any child or staff appears to have severe symptoms, call emergency services immediately. Before transferring to a medical facility, notify the transfer team and medical facility if the individual is suspected to have COVID-19. Severe symptoms include the following: extreme difficulty breathing (i.e. not being able to speak without gasping for air), bluish lips or face, persistent pain or pressure in the chest, severe persistent dizziness or lightheadedness, new confusion or inability to rouse someone, or new seizure or seizures that won't stop.

## 5. Isolation and Discharge of Sick Children and Staff

- A. **Planning for Isolation and Discharge:** Programs must take the following actions to prepare for a potential exposure.
- (1) Designate a separate space to isolate children or staff who may become sick, with the door closed (or a solid barrier) if possible. Isolated children must be supervised at all times. A private or separate bathroom must be made available for use by sick individuals only. Others must not enter isolation room/space without PPE appropriate to the care setting. A location with an open window and/or good air circulation is optimal. In family child care settings with one adult, staff should isolate children who may become sick using a barrier to maintain adequate supervision of all children.
  - (2) If your facility does not have designated isolation rooms/spaces, determine a pre-specified location/facility to which you will be sending patients presenting with COVID-19 symptoms.
  - (3) Have an emergency back-up plan for staff coverage in case a child or staff becomes sick.
  - (4) Know the contact information for the local board of health in the city or town in which the program is located.
  - (5) Have masks other cloth face coverings available for use by children and staff who become symptomatic, until they have left the premises of the program.
  - (6) Designate a separate exit from the exit used to regularly exit for those being discharged due to suspected infection.
- B. **If a Child Becomes Symptomatic:** If a child becomes symptomatic, programs must follow the protocols below:
- (1) Immediately isolate from other children and minimize exposure to staff.
  - (2) Whenever possible, cover children's (age 2 and older) noses and mouths with a mask or cloth face covering.
  - (3) Contact the child's parents and send home as soon as possible.

- (4) Follow the program's plan for the transportation of a child who has developed symptoms and who relies on program transportation.
- C. If a Staff Becomes Symptomatic: If a staff member becomes symptomatic, they must cease child care duties immediately and be removed from others until they can leave. Staff must regularly self-monitor during the day to screen for new symptoms. If new symptoms are detected among a staff member, follow the requirements above in Section 5A-B on how to handle symptomatic individuals.
- D. If a Child or Staff Contracts COVID-19: Sick children or employees who are COVID-19 positive or symptomatic and presumed to have COVID-19 must not return until they have met the criteria for discontinuing home isolation and have consulted with a health care provider. Determine the date of symptom onset for the child/staff. Determine if the child/staff attended/worked at the program while symptomatic or during the two days before symptoms began. Identify what days the child/staff attended/worked during that time. Determine who had close contact with the child/staff at the program during those days (staff and other children).
  - (1) If the individual tests positive for COVID-19 but is asymptomatic, isolation may be discontinued when at least 10 days have passed from the date of the positive test, as long as the individual remains asymptomatic. For example, if the individual was tested on April 1, isolation may be discontinued on or after April 11.
- E. Notifying Required Parties: In the event that a program experiences an exposure, programs must notify the following parties.
  - (1) Employees and families about exposure but maintain confidentiality.
  - (2) Local board of health if a child or staff is COVID-19 positive.
  - (3) Funding and licensing agencies if a child or staff member has tested positive.
- F. Self-Isolating Following Exposure or Potential Exposure: In the event that a staff member or child is exposed to a sick or symptomatic person, the following protocols must be followed.
  - (1) If a child or staff has been exposed to COVID-19, regardless of whether the individual has symptoms or not, the child or staff must not be permitted to enter the program space and must be sent home. Exposed individuals must be directed to stay home for at least 14 days after the last day of contact with the person who is sick. The program must consult the local board of health for guidance on quarantine for other children and staff and what additional precautions will be needed to ensure the program space is safe for continued child care services.
  - (2) If an exposed child or staff subsequently tests positive or their doctor says they have confirmed or probable COVID-19, they must be directed to stay home for a minimum of 10 days from the 1st day of symptoms appearing AND be fever-free for 72 hours without fever reducing medications AND experience significant improvements in symptoms. Release from isolation is under the jurisdiction of the local board of health where the individual resides.
  - (3) If a child's or staff's household member tests positive for COVID-19, the child or staff must self-quarantine for 14 days after the last time they could have been exposed.
- G. If an Exposed Child or Staff Remains Asymptomatic and/or Tests Negative for COVID-19: If the exposed individual remains asymptomatic and/or tests negative for COVID-19, they must remain in quarantine and continue to monitor for the full 14 days.

## 6. Hygiene and Health Practices

- A. Resources and Supplies: Plan ahead to ensure that the program has adequate supplies to promote frequent and effective hygiene behaviors. Programs must have the following materials and supplies:

- (1) Handwashing facilities with soap and water must be readily accessible to all children and staff. Post handwashing instructions near every handwashing sink and where they can easily be seen by children and staff.
  - (2) Hand sanitizer with at least 60% alcohol may be utilized at times when handwashing is not available, as appropriate to the ages of children and only with written parent permission to use.<sup>6</sup> Hand sanitizer must be stored securely and used only under supervision of staff. Staff must make sure children do not put hands wet with sanitizer in their mouth and must teach children proper use.
  - (3) Hand hygiene stations must be set up at the entrance of the premises, so that children can clean their hands before they enter. If a sink with soap and water is not available, provide hand sanitizer with at least 60% alcohol next to parent sign-in sheets and allow use in accordance with the guidelines above. If hand sanitizer use is not appropriate or not approved and there is no soap and water at the entrance, children must be instructed to go to the nearest handwashing station upon entry. Keep hand sanitizer out of children's reach and supervise use.
  - (4) If possible, place sign-in stations outside the program space and have contactless sign in, such as application or web based. If pens are required, they must be disinfected between uses or must be provided for individual only use.
- B. When to Wash Hands: Children and staff must wash their hands or use hand sanitizer often, making sure to wash all surfaces of their hands (e.g., front and back, wrists, between fingers). Reinforce to staff and children that they must be regularly washing their hands with soap and water for at least 20 seconds when the following criteria are met:
- (1) Upon entry into and exit from program space;
  - (2) When coming in to the program space from outside activities;
  - (3) Before and after eating;
  - (4) After sneezing, coughing or nose blowing;
  - (5) After toileting and diapering;
  - (6) Before handling food;
  - (7) After touching or cleaning surfaces that may be contaminated;
  - (8) After using any shared equipment like toys, computer keyboards, mouse, climbing walls;
  - (9) After assisting children with handwashing;
  - (10) Before and after administration of medication;
  - (11) Before entering vehicles used for transportation of children;
  - (12) After contact with facemask or cloth face covering; and
  - (13) Before and after changes of gloves.
- C. Cover Coughs or Sneezes: Children, families, and staff must avoid touching their eyes, nose, and mouth. Cover coughs or sneezes with a tissue, then throw the tissue in the trash and clean hands with soap and water or hand sanitizer (if soap and water are not readily available and with parental permission and careful supervision as appropriate to the ages of the child).
- D. Additional Healthy Habits: Programs are encouraged to teach, model, and reinforce the following healthy habits.

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<sup>6</sup> While hand sanitizer may be used by children over 2 years of age with parental permission, handwashing is the preferred and safer method.

- (1) Staff must know and follow the steps needed for effective handwashing (use soap and water to wash all surfaces of their hands for at least 20 seconds, wait for visible lather, rinse thoroughly and dry with individual disposable towel).
- (2) Build in monitored handwashing for children at all necessary times throughout the day (e.g., upon arrival, before and after meals, after toileting and diapering, after coughing and sneezing, after contact with bodily fluids). Post visual steps of appropriate handwashing to assist children or cue them to sing the "Happy Birthday" song TWICE (approx. 20 seconds) as the length of time they need to wash their hands.
- (3) Assist children with handwashing.
- (4) Keep hand sanitizer out of the reach of children and monitor use closely. Due to its high alcohol content, ingesting hand sanitizer can be toxic for a child. Supervise children when they use hand sanitizer to make sure they rub their hands until completely dry, so they do not get sanitizer in their eyes or mouth.
- (5) Explain to children why it is not healthy to share drinks or food, particularly when sick.
- (6) Teach children to use tissue to wipe their nose and to cough inside their elbow. They must wash their hands with soap and water immediately afterwards.
- (7) Ask parents and caregivers to wash their own hands and assist in washing the hands of their children before dropping off, prior to coming for pick up, and when they get home.

## **7. Personal Protective Equipment (PPE) and Face Masks and Coverings**

### **A. Face Masks and Coverings: Programs must encourage the wearing of masks or cloth face coverings during the program day. Whenever 6 feet of physical distancing is not possible, masks must be worn.**

- (1) To slow the spread of COVID-19, program staff are encouraged to wear a cloth face covering while serving children and interacting with parents and families. Program staff are required to wear a cloth face covering whenever 6 feet of physical distancing is not possible. Programs are encouraged to consider the use of transparent face coverings to allow for the reading of facial expressions, which is important for child development.
- (2) When possible and at the discretion of the parent or guardian of the child, programs should encourage the wearing of masks or cloth face coverings for children age 2 and older who can safely and appropriately wear, remove, and handle masks. Additional guidance on use of face coverings and masks by children is as follows:
  - (a) Children under the age of 2 years should not wear face coverings or masks.
  - (b) When children can be safely kept at least 6 feet away from others, then they do not need to be encouraged to wear a mask.
  - (c) Masks must not be worn while children are eating/drinking, sleeping, and napping. Strict and consistent physical distancing must be practiced at all times during these activities. Masks do not need to be worn while engaging in active outdoor play, if children are able to keep physical distance from others.
  - (d) Children 2 years of age and older must be supervised when wearing a mask. If wearing the face covering causes the child to touch their face more frequently, staff must reconsider whether the mask is appropriate for the child.
- (3) Families should provide their children with a sufficient supply of clean masks and face coverings for their child to allow replacing the covering as needed. These families must have a plan for routine cleaning of masks and face coverings, clearly mark masks with child's name and room number, if applicable, and clearly distinguish which side of the covering should be worn facing outwards so they

- are worn properly each day. If families are unable to provide masks, programs should provide a mask for children and youth, as necessary. Masks and face coverings must be routinely washed (at least daily and any time the mask is used or becomes soiled) depending on the frequency of use. When possible, masks must be washed in a washing machine in hot water and dried fully before using again. If a washing machine is unavailable, masks must be washed with soap and hot water and allowed to dry fully before using again.
- (4) If using a disposable mask, follow [CDC guidance](#) on proper daily removal. Grasp bottom ties or elastics of the mask, then the ones at the top, and remove without touching the front. Discard in a waste container and wash hands or use an alcohol-based hand sanitizer immediately.
  - (5) Programs must enforce the wearing of face masks by **parents or guardians** when on the premises and at all times during drop-off and pick-up. Programs must regularly remind families and staff that all individuals are encouraged to adhere to the [CDC's recommendations](#) for wearing a mask or cloth face covering whenever going out in public and/or around other people.
  - (6) Programs must teach and reinforce use of cloth face coverings among all program staff. Face coverings are most essential at times when social distancing is not possible. Staff must be frequently reminded not to touch the face covering and to wash their hands frequently. Information must be provided to all staff on proper use, removal, and washing of cloth face coverings.
- B. Exceptions to Use of Face Masks/Coverings: Exceptions for wearing face masks include situations that may inhibit an individual from wearing a face mask safely. These may include, but are not limited to:
- (1) Children under the age of 2 years;
  - (2) Children who cannot safely and appropriately wear, remove, and handle masks;
  - (3) Children who have difficulty breathing with the face covering or who are unconscious, incapacitated, or otherwise unable to remove the cover without assistance;
  - (4) Children with severe cognitive or respiratory impairments that may have a hard time tolerating a face mask;
  - (5) Children where the only option for a face covering presents a potential choking or strangulation hazard;
  - (6) Individuals who cannot breathe safely with a face covering, including those who require supplemental oxygen to breathe;
  - (7) Individuals who, due to a behavioral health diagnosis or an intellectual impairment, are unable to wear a face covering safely; and
  - (8) Individuals who need to communicate with people who rely upon lip-reading.
- C. When to Use Gloves: Program staff must wear gloves when appropriate and at all times during the following activities. Programs should consult with a child's medical records and identify any allergies when determining type of gloves to use. Handwashing or use of an alcohol-based hand sanitizer before and after these procedures is always required, whether or not gloves are used.
- (1) Diapering;
  - (2) Food preparation; and
  - (3) Screening activities requiring contact.
- D. Additional Guidance on Using Gloves: To reduce cross-contamination, disposable gloves should always be discarded after the following instances. After removing gloves for any reason, hand hygiene should be performed with alcohol-based hand sanitizer or soap and water.



- (1) Visible soiling or contamination with blood, respiratory or nasal secretions, or other body fluids occurs.
- (2) Any signs of damage (e.g., holes, rips, tearing) or degradation are observed.
- (3) Maximum of four hours of continuous use.
- (4) Removing gloves for any reason. Previously removed gloves should not be re-donned as the risk of tearing and contamination increases. Therefore, disposable glove “re-use” should not be performed.
- (5) In addition, gloves should be removed following activities where glove usage is required including diapering, food preparation, and screening activities requiring contact.

## **8. Cleaning, Sanitizing, and Disinfecting**

### **A. Resources and Supplies:** Below is information about what supplies must be used for cleaning, sanitizing, and disinfecting.

- (1) Programs must use [EPA-registered disinfectants and sanitizers](#) for use against COVID-19. Follow directions on the label, including ensuring that the disinfectant or sanitizer is approved for that type of surface (such as food-contact surfaces).
- (2) When EPA-approved disinfectants are not available, a bleach solution can be used (for example, 1/3 cup of household bleach added to 1 gallon of water OR 4 teaspoons bleach per quart of water, or 70% alcohol solutions).
- (3) All bleach and water dilutions must be freshly mixed every 24 hours. Bleach solutions must be prepared daily to ensure their ability to safely sanitize or disinfect. When preparing sanitizing or disinfecting dilutions always add bleach to water. This helps to avoid bleach splashes caused by adding water to bleach. Use either the sanitizing or the disinfecting dilution as specified above.
- (4) Many cleaning agents can be irritants and trigger acute symptoms in children with asthma or other respiratory conditions. Programs must not prepare cleaning solutions in close proximity to children.
- (5) Check the label to see if your bleach is intended for disinfection, and ensure the product is not past its expiration date. Unexpired household bleach will be effective against COVID-19 when properly diluted. Some bleaches, such as those designed for safe use on colored clothing or for whitening may not be suitable for disinfection.
- (6) Follow manufacturer’s instructions for application and proper ventilation. Never mix household bleach with ammonia or any other cleanser. Leave solution on the surface for at least 1 minute.
- (7) Programs shall use child-safe cleaning, sanitizing, and disinfecting solutions and children should never be present when mixing solutions.
- (8) Only single use, disposable paper towels shall be used for cleaning, sanitizing, and disinfecting. Sponges shall not be used for sanitizing or disinfecting.
- (9) All sanitizing and disinfecting solutions must be labeled properly to identify the contents, kept out of the reach of children, and stored separately from food items. Do not store sanitizing and disinfecting solutions in beverage containers.
- (10) Avoid aerosols, because they contain propellants that can affect breathing. Pump or trigger sprays are preferred.

### **B. Proper Usage:** Proper guidelines must be followed when cleaning, sanitizing, and disinfecting.

- (1) All sanitizing and disinfecting solutions must be used in areas with adequate ventilation and never in close proximity to children as to not trigger acute symptoms in children with asthma or other

respiratory conditions. Do not spray chemicals around children. If possible, move children to another area or have someone distract them away from the area where a chemical is being used.

- (2) To ensure effective cleaning and disinfecting, always clean surfaces with soap and water first, then disinfect using a diluted bleach solution, alcohol solution with at least 70% alcohol, or an EPA-approved disinfectant for use against the virus that causes COVID-19. Cleaning first will allow the disinfecting product to work as intended to destroy germs on the surface.
- (3) Use all cleaning products according to the directions on the label. Follow the manufacturer's instructions for concentration, application method, and contact time for all cleaning and disinfection products.
- (4) Surfaces and equipment must air dry after sanitizing or disinfecting. Do not wipe dry unless it is a product instruction. Careful supervision is needed to ensure that children are not able to touch the surface until it is completely dry.
- (5) Keep all chemicals out of the reach of children both during storage and in use.
- (6) Keep chemicals in their original containers. If this is not possible, label the alternate container to prevent errors.
- (7) Do not mix chemicals. Doing so can produce a toxic gas.

C. General Guidelines for Cleaning, Sanitizing, and Disinfecting: Programs must follow these general guidelines for cleaning, sanitizing, and disinfecting.

- (1) Intensify the program's routine cleaning, sanitizing, and disinfecting practices, paying extra attention to frequently touched objects and surfaces, including doorknobs, bathrooms and sinks, keyboards, and bannisters.
- (2) Clean and disinfect toys and activity items, including sports and specialty camp activity equipment (e.g. and climbing walls), used by children more frequently than usual and take extra care to ensure that all objects that children put in their mouths are removed from circulation, cleaned, and sanitized before another child is allowed to use it.
- (3) While cleaning and disinfecting, staff must wear gloves as much as possible. Handwashing or use of an alcohol-based hand sanitizer after these procedures is always required, whether or not gloves are used.

D. Cleaning, Sanitizing, and Disinfecting Indoor Play Areas: Programs must follow these guidelines for cleaning, sanitizing, and disinfecting indoor play areas.

- (1) Children's books, like other paper-based materials such as mail or envelopes, are not considered a high risk for transmission and do not need additional cleaning or disinfection procedures. Programs should conduct regular inspection and disposal of books or other paper-based materials that are heavily soiled or damaged.
- (2) Machine washable cloth toys cannot be used at all.
- (3) Toys that children have placed in their mouths or that are otherwise contaminated by body secretions or excretions must be set aside until they are cleaned by hand by a person wearing gloves. Clean with water and detergent, rinse, sanitize with an EPA-registered sanitizer, and air-dry or clean in a mechanical dishwasher.
- (4) For electronics, such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present. Consider putting a wipeable cover on electronics. Follow manufacturer's instruction for cleaning and disinfecting. If no guidance, use alcohol-based wipes or sprays containing at least 70% alcohol. Wait in accordance with manufacturer's directions and then dry surface thoroughly or allow to air dry. Provide cleaning materials for older children to clean their own electronics.

E. Cleaning, Sanitizing, and Disinfecting Outdoor Play Areas: Programs must follow these guidelines for cleaning, sanitizing, and disinfecting outdoor play areas.

- (1) Communal parks and playgrounds must not be utilized. This includes public offsite playgrounds as well as playgrounds shared by multiple programs or houses. Playgrounds shared by multiple programs and houses may be used provided there is a plan for proper cleaning and disinfection between each group's use.
- (2) High touch surfaces made of plastic or metal, including play structures, tables and benches, should be frequently cleaned and disinfected.
- (3) Cleaning and disinfection of wooden surfaces or groundcovers (mulch, sand) is not recommended.
- (4) Communal pools must not be utilized. Programs may use their own indoor and outdoor swimming pools in accordance with guidance. All pools must meet the regulatory requirements of 105 CMR 435.00: Minimum Standards for Swimming Pools, State Sanitary Code: (Chapter V), as well as any additional more restrictive MA state or local requirements or orders in response to COVID-19. Handrails and pool ladders must be disinfected frequently throughout the program day.

F. Cleaning, Sanitizing, and Disinfecting After a Potential Exposure in Day Programs: If a program suspects a potential exposure, they must conduct cleaning and disinfecting as follows.

- (1) Close off areas visited by the ill persons. Open outside doors and windows and use ventilating fans to increase air circulation in the area. Wait 24 hours or as long as practical before beginning cleaning and disinfection. Programs must plan for availability of alternative space while areas are out of use.
- (2) Cleaning staff must clean and disinfect all areas such as offices, bathrooms, common areas, shared electronic equipment (e.g., tablets, touch screens, keyboards) used by the ill persons, focusing especially on frequently touched surfaces.

G. Additional Considerations: Programs must also consider the following precautions.

- (1) Staff clothing must not be worn again until after being laundered at the warmest temperature possible.
- (2) Programs must comply with OSHA's standards on Bloodborne Pathogens (29 CFR 1910.1030), including proper disposal of regulated waste and PPE (29 CFR 1910.132).
- (3) Programs shall follow CDC infection control guidelines designed to protect individuals from exposure to diseases spread by blood, bodily fluids, or excretions that may spread infectious disease. Health precautions include, but are not limited to, the use of PPE, proper disposal containers for contaminated waste, handwashing and proper handling of bodily waste.
  - (a) Non-latex gloves shall be provided and used for the clean-up of blood and bodily fluids;
  - (b) Used gloves and any other materials containing blood or other bodily fluids shall be thrown away in a lined, covered container. Only material saturated/dripping with blood is considered medical waste and must be stored and disposed of pursuant to the [regulations](#). Materials such as band-aids, tissues and others with minimal blood are not considered medical waste;
  - (c) Contaminated clothing shall be sealed in a plastic container or bag, labeled with the child's name, and returned to the parent at the end of the day; and
  - (d) Sharps waste shall be stored and disposed of in appropriate sharps containers with the word biohazard and the universal biohazard symbol.

## 9. Strategies to Reduce the Risk of Transmission

- A. **Physical Distancing:** Programs must maintain at least 6 feet of distance at all times and limit contact between individuals and groups, whenever possible. When 6 feet is not possible, individuals must wear masks or cloth face coverings.
- (1) In order to maintain a distance of 6 feet between individuals, programs must have a minimum of 42 square feet per child, with 144 sq. ft. per child being the ideal to maintain proper physical distancing.
  - (2) Physical distancing must be practiced by children and staff at all times, including but not limited to:
    - (a) During transitions (e.g., waiting for bathrooms)
    - (b) During meal times (e.g., if a cafeteria or group dining room is typically used, serve meals in classrooms instead. Put each child's meal on a plate, to limit the use of shared serving utensils. If classroom must be used, clean and disinfect tables between meal shifts.)
    - (c) While traveling to and from the outdoors
    - (d) During all activities
    - (e) During sleep, rest, or quiet play time (i.e. space out seating and bedding)
    - (f) While using transportation (e.g., buses)
  - (3) Prevent risk of transmitting COVID-19 by avoiding immediate contact (such as shaking or holding hands, hugging, or kissing), as well as by mediated contact.
  - (4) Stagger drop offs/pick-ups.
  - (5) Store children's belongings in a manner where they do not touch. Individually labeled storage containers, cubbies, or separate; designated areas must be used.
  - (6) Stagger recess and play outside one group at a time.
  - (7) Refrain from games and activities that encourage physical contact or proximity of less than 6 feet, like tag or circle time.
  - (8) Spaces for children must be organized in a way that allows staff to enforce and maintain consistent physical distancing guidelines. Physically rearrange the room to promote individual play, including setting up individual play activity stations like puzzles and art. Space activity areas/centers as far apart as possible.
  - (9) Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment, etc. assigned to a single child) or limit use of supplies and equipment by one group of children at a time and clean and disinfect between uses. If possible, touchless trash cans should be utilized and located throughout the program space.
  - (10) Limit gatherings, events, and extracurricular activities to those that can maintain social distancing. Support proper hand hygiene. Do not host events that encourage non-essential adults to visit the program.
  - (11) Close communal use spaces, such as game rooms or dining halls, if possible. If this is not possible, stagger use and disinfect in between uses or divide into two rooms. Programs may have multiple groups of ten, provided social distancing is maintained between and within groups. When dividing rooms, create a clear barrier with cones, chairs, tables, etc. to ensure a minimum six feet of distance.
  - (12) Where possible, arrange for administrative staff to telework from their homes.

- (13) Programs must limit travel off the premises for all children and staff. Programs must limit travel outside of the program, including canceling all field trips and inter-agency, or program, groups and activities. Hiking and outdoor activities may be conducted on program grounds.
- (14) Activities that require or may require direct staff support, close contact, or rescue must not be conducted, except where necessary to support participation for children with special needs.
- (15) Limit the number of children permitted to use pool facilities at the same time. Determinations must consider how many people can be at the pool facility and still maintain 6 feet distancing.

## 10. Transportation

- A. Transportation Usage: Group transportation should only be provided during the phased reopening when there is no other option to transport children to and from the program. Programs intending to provide transportation services shall follow the guidance below.
  - (1) Parents must screen their children prior to boarding a vehicle, including checking symptom and temperature.
  - (2) Parents must provide car seats or booster seats as appropriate, clearly labeled with the child's name in order to prevent the sharing of car or booster seats.
  - (3) Social distancing and group size requirements outlined above must be maintained while in transit. Because close seating on vehicles makes person-to-person transmission of respiratory viruses more likely, programs providing transportation to child care facilities must maximize space between riders (e.g., one rider per seat in every other row) and follow requirements for wearing masks or face coverings. Windows must be kept open.
  - (4) If not possible nor comfortable to open windows, set ventilation system to high. Do not recirculate conditioned air.
- B. Developing a Transportation Plan: Programs intending to provide transportation must develop a transportation plan for following health and safety protocols. Additional requirements are as follows.
  - (1) Plans must include protocols for screening drivers, monitors, and/or children.
  - (2) Plans must include strategies for transporting children that may have become sick but rely upon transportation provided by programs.
  - (3) Plans must include strategies for minimizing the time children are in group transportation.
  - (4) Plan must include schedule for routine cleaning of vehicles, detailed below.
  - (5) Drivers and monitors must be trained on the transportation plan prior to reopening.
  - (6) Prior to sending kids by bus, staff must perform at a minimum a visual wellness check and symptom screen.
  - (7) Staff should assist children with washing or sanitizing hands upon arrival after exiting the bus, van, or vehicle and prior to departure before boarding the bus, van, or vehicle.
- C. Screening Protocols: Designated staff must screen each driver and monitor before entering the vehicle following the screening protocols included in Section 4A.
- D. Routine Cleaning of Vehicles: The interior of each vehicle must be cleaned and either swept or vacuumed thoroughly after each morning and evening route and disinfected at least once each day.
  - (1) Clean the area prior to disinfection to remove all surface matter.

- (2) Use EPA-Registered Products for Use Against Novel Coronavirus SARS-CoV-2 (the cause of COVID-19) to clean high-touch surfaces, including buttons, handholds, pull cords, rails, steering wheels, door handles, shift knobs, dashboard controls, and stanchions.
  - (3) Dust- and wet-mop vehicle floors.
  - (4) Remove trash.
  - (5) Wipe heat and air conditioner vents.
  - (6) Spot cleaning walls and seats.
  - (7) Dust horizontal surfaces.
  - (8) Clean spills.
  - (9) If soft or porous surfaces (e.g., fabric seats, upholstery, carpets) are visibly dirty, clean them using appropriate cleaners and then disinfect soft or porous surfaces using EPA Registered Antimicrobial Products for Use Against Novel Coronavirus SARS-CoV-2.
  - (10) Staff should be trained to use disinfectants in a safe and effective manner and to clean up potentially infectious materials and body fluid spills.
- E. Precautions for Transportation Operators: Transportation operations shall take the following precautions when transporting children.
- (1) For transit operators, potential sources of exposure include having close contact with a vehicle passenger with COVID-19, by contacting surfaces touched or handled by a person with COVID-19, or by touching your mouth, nose, or eyes.
  - (2) Request passengers avoid standing or sitting within 6 feet of the vehicle driver, wherever possible.
  - (3) Drivers and monitors must wear masks or face coverings. Riders over the age of 2 should be encouraged to wear masks or face coverings following the guidance included in Section 5.
  - (4) Avoid touching surfaces often touched by vehicle passengers.
  - (5) Use gloves if required to touch surfaces contaminated by bodily fluids.
  - (6) Proper hand hygiene is an important infection control measure. Wash your hands regularly with soap and water for at least 20 seconds, especially:
    - (a) After going to the bathroom;
    - (b) Before eating;
    - (c) After blowing your nose, coughing, or sneezing; and
    - (d) Upon entering and exiting the vehicle.
    - (e) If soap and water are not readily available, use an alcohol-based hand sanitizer containing at least 60% alcohol.
  - (7) Practice routine cleaning and disinfection of frequently touched surfaces, including surfaces in the driver cockpit commonly touched by the driver.
  - (8) Ensure drivers and monitors have adequate supplies of soap, paper towels, tissues, hand sanitizers, cleaning supplies, and garbage bags.
- F. If a Driver/Monitor is Sick: If driver and/or monitor are sick, they must stay home and not come to work. Do not schedule them to work if they are sick.

- G. Transportation for Children with Special Needs and Vulnerable Children: To ensure that children with special needs and vulnerable children who rely on transportation will be able to access program services, the following transportation protocols must be followed.
- (1) Screenings must be conducted before children, vehicle drivers, and vehicle staff board the bus.
  - (2) Transportation practices must adhere to social distancing guidelines, as discussed above.
  - (3) Vehicle drop off must be adjusted to meet social distancing guidelines. Vehicles must off load and load one vehicle at a time, unless the location allows for enough distance between vehicles.

## 11. Food Safety

- A. General Regulations: Programs must follow the food safety guidelines below.
- (1) Whenever possible, snacks must be pre-packaged or ready to serve in individual portions to minimize handling and preparation. Meals shall not be served family style.
  - (2) To minimize potential spread of infection and to promote physical distancing, cafeterias and group dining rooms must be avoided. If there are no alternatives, programs must adequately social distance during meals and add extra meal shifts.
  - (3) Multiple children shall not use the same serving or eating utensils. Each child must have an individual cup to use.
  - (4) Sinks used for food preparation must not be used for any other purposes.
  - (5) Staff must ensure children wash hands prior to and immediately after eating.
  - (6) Staff must wash their hands before preparing food and after helping children to eat.
  - (7) Tables, chairs, high chairs, and high chair trays used for meals need to be cleaned and sanitized before and after use.
  - (8) All food contact surfaces, equipment, and utensils used for the preparation, packaging, or handling of food products must be washed, rinsed, and sanitized before each use. Additionally, programs must frequently clean non-food contact surfaces, such as doorknobs, tabletops, and chairs. Use sanitizers approved by the EPA for use against COVID-19 and for food-contact surfaces.
  - (9) When disinfecting for coronavirus, EPA recommends following the product label use directions for enveloped viruses, as indicated by the approved emerging viral pathogen claim on the master label. If the directions for use for viruses/viricidal activity list different contact times or dilutions, use the longest contact time or most concentrated solution. Be sure to follow the label directions for FOOD CONTACT SURFACES when using the chemical near or on utensils and food contact surfaces.

## 12. Children with Special Needs, Vulnerable Children, and Infants and Toddlers

- A. Understand Child's Healthcare Needs: To ensure that programs are adequately prepared to provide safe and appropriate services to children with special needs and vulnerable children, the following steps must be taken.
- (1) Review medical information submitted by parents and determine whether and how many high-risk children are in attendance.
  - (2) Reach out to parents of high-risk children and encourage them to discuss with their healthcare provider about whether the program is a safe option for the child and if additional protections are necessary.
  - (3) Discuss with the parent any concerns they have with the new protocols and how you can best help their child understand and adhere as close as possible to the health and safety requirements.

- B. Supporting Children with Special Needs in Programs: Children with special needs will require unique supports in programs that may make it less possible to practice social distancing and will require ample staff support to carry out the necessary hygiene practices. Programs must ensure that the program is adequately staffed and that staff are prepared and properly trained to accommodate children's needs.
- (1) Staff must be prepared to provide hands-on assistance to children with special needs for activities of daily living such as feeding, toileting, and changing of clothes. To protect themselves, staff who care for children requiring hands-on assistance for routine care activities, including toileting, diapering, feeding, washing, or dressing, and other direct contact activities must wear a long-sleeved, button down, oversized shirt over their clothing and wear long hair up or tied back during all activities requiring direct contact with a child. Staff must change outer clothing if body fluids from the child get on it. Staff must change the child's clothing if body fluids get on it. Soiled clothing must be placed in a plastic bag until it can be sent home with the child to be washed.
  - (2) Staff must be adequately trained and prepared to support children with health care needs with the necessary provisions of health care such as administration of medication needed throughout the day, tube feedings, blood sugar checks, and allergies to certain foods. For more invasive procedures, staff must protect themselves by wearing a gown or other body covering (e.g., an oversized button-down, long sleeved shirt, etc.), eye protection, and mask.
  - (3) Children with special needs may be unable to comply with face covering because of intellectual, behavioral, or sensory issues. To minimize the risk of infection for children who are unable to wear a face covering, physical distancing must be maintained whenever possible and staff must wear a face covering at all times, including when working with a child who is unable to wear a face covering. Programs serving children who are deaf or hard of hearing are encouraged to consider the use of transparent face coverings to facilitate the reading of lips and facial expressions.
  - (4) Staff-to-child ratios must be higher for programs serving children with special needs, given their need for more individualized attention. Groupings for children with special needs must be assigned based on the developmental level of the child and the impact of the disability on the child with regard to their ability to adhere to PPE requirements and social distancing rather than their chronological age. Smaller groups must be formed where the child requires more hands on assistance and a higher number of staff required to care for the children. Some children with special needs will require 1:1 assistance. Programs must refer to individual treatment plans or IEPs when assessing required ratios.
- C. Caring for Infants and Toddlers: Infants and toddlers will need to be held. Staff must practice stringent hygiene and infection control practices to keep themselves and the young children they care for healthy and safe while in care.
- (1) To protect themselves, staff who care for infants and toddlers must wear a long-sleeved, button down, oversized shirt over their clothing and wear long hair up or tied back during all activities requiring that a toddler is held.
  - (2) Staff must change outer clothing if body fluids from the child get on it.
  - (3) Staff must change the child's clothing if body fluids get on it.
  - (4) Soiled clothing must be placed in a plastic bag until it can be sent home with the child to be washed.
  - (5) All staff must follow safe and sanitary diaper changing procedures. Procedures must be posted in all diaper changing areas, and must include:
    - (a) Prepare (includes gathering all supplies, washing hands, and putting on gloves).
    - (b) Clean the child.
    - (c) Remove trash (soiled diaper, wipes, and gloves).
    - (d) Put on clean gloves.



- (e) Replace diaper.
  - (f) Wash child's hands.
  - (g) Clean up diapering station.
  - (h) Remove and dispose of gloves.
  - (i) Wash hands.
- (6) During washing and feeding activities, staff must protect themselves by wearing a gown or other body covering (e.g., an oversized button-down, long sleeved shirt, etc.) and eye protection where available. Staff with long hair must tie their hair back so it is off the collar and away from the reach of the child.
- (a) Child care providers must wash their hands, neck, and anywhere touched by a child's secretions.
  - (b) Child care providers must change the child's clothes if secretions are on the child's clothes. They must change the button-down shirt, if there are secretions on it, and wash their hands again.
  - (c) Contaminated clothes must be placed in a plastic bag or washed in a washing machine.
  - (d) Infants and toddlers and their providers must have multiple changes of clothes on hand.
- (7) As infants and toddlers are not able to verbalize when they don't feel well, staff must be attentive to any changes in a very young child's behavior. If the child starts to look lethargic, and is not eating as well, staff must notify the parent to determine whether the child's pediatrician must be contacted. If a toddler is showing signs of respiratory distress and having difficulty breathing, staff must call 911 and notify the parents immediately.

### 13. Recreational Camps and Programs

- A. General Guidance for Recreational Camps and Programs: Recreational Camps and Programs must operate under the following guidance as well as the sections above, where appropriate, excluding Sections 1, 2, and 3. Residential Camps and other overnight stays are not permitted until further notice.
- (1) Recreational Camps and Programs may operate with Massachusetts campers and staff with activity restrictions and limited opening for groups  $\leq 12$ . Camps may have multiple groups of 12 campers and counselors, provided social distancing is maintained between and within groups. Camps may not exceed the camper to counselor ratios in in Camp Regulations 105 CMR 430.101.
  - (2) Visitors (including parents) and volunteers are not permitted.
  - (3) Massachusetts residency is required for campers and staff at Recreational Camps and Programs at this time. Additional guidance will be issued by the DPH regarding residency requirements for future phases.
  - (4) Recreational Camps must comply with 105 CMR 430 Minimum Standards for Recreational Camps for Children: State Sanitary Code Chapter IV as well as any additional more restrictive MA state or local requirements or orders in response to COVID-19. Camps are responsible for ensuring their operations are updated to comply with new guidance and orders.
- B. Planning for Recreational Camps and Programs: All camps that are allowed to operate during the current phase must meet the following planning requirements
- (1) Recreational Camps and Programs plans must be updated to address how they will meet the new health and safety requirements associated with COVID-19. For Recreational Camps, plans must be included into Staff Training and Orientation and provided in writing and included in or in addition to the written camp Health Care Policy and other relevant procedures (105 CMR 430.159). Elements planning for Recreational Camps and Programs must include the following:

- (a) A plan to address cleaning, disinfecting, sanitizing and frequency. This must include a daily staff cleaning schedule (before, during, and after activities) to ensure that all areas, materials, furniture, and equipment are properly cleaned, sanitized, or disinfected.
  - (b) A plan for identifying and handling sick, symptomatic, and exposed children and staff that includes but is not limited to daily screening checks, temperature screenings, location of screening activities, and staff responsible for screening. All staff conducting screenings should be trained to do so by the Health Care Consultant.
  - (c) A plan for the isolation and discharge of sick, symptomatic, and exposed children or staff, including procedures for contacting parents immediately, criteria for seeking medical assistance, transportation of a child/staff who has developed symptoms related to COVID-19 mid-day and who rely on camp transportation, mitigation of transmission until the sick individual can safely leave the camp, and immediately notifying the local board of health.
- (2) Recreational Camps and Programs must ensure that their sick leave policies are flexible and promote the importance of staff not coming to work if they have a frequent cough, sneezing, fever, difficulty breathing, chills, muscle pain, headache, sore throat, or recent loss of taste or smell, or if they or someone they live with has been diagnosed with COVID-19.
- (3) Recreational Camps and Programs must designate a senior camp staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- (4) Recreational Camps and Programs must develop a plan for food service. Snacks and meals should be brought from home, be pre-packaged, or be ready to serve in individual portions to minimize handling and preparation. Where this is not feasible, staff must prepare and serve meals. Meals should not be served family style.
- (5) Recreational Camps and Programs must develop a plan for safe vendor deliveries, if applicable. Non-contact delivery protocols must be arranged whenever possible.
- (6) Recreational Camps and Programs must develop a plan for handling camp closings and staff absences. Determine how the facility will communicate with staff and parents. Determine who will inform local board of health, the Department of Public Health Community Sanitation Program, and other appropriate audiences.
- (7) Recreational Camps and Programs must have a plan for sharing information and guidelines with parents that includes the following:
  - (a) A system to check with parents daily) on the health status of their children when children are dropped off at the facility.
  - (b) Email addresses and home, work, and mobile phone numbers from parents of children at the camp so that staff can reach them at any time.
  - (c) A tested communication system with parents, children at the camp, all staff, facility and/or grounds management, and emergency medical services.
  - (d) Information on COVID-19 including symptoms, transmission, prevention, and when to seek medical attention. Encouraging parents to share the information with their children as appropriate.
  - (e) Provide parents with information on the camp's policies for preventing and responding to infection and illness. This must be given to the camper's parents/guardians and not just provided on a website. Provide information in the primary languages spoken by the parents, if possible

- (8) Recreational Camps and Programs must develop safe pickup/drop off procedures to maintain social distancing and prevent the mixing of campers.
    - (a) Encourage the same family member to be pickup/drop off person.
    - (b) Explain new procedures with parents prior to the first drop-off.
    - (c) Confirm the pickup person is camper's parent, legal guardian, or other individual designated in writing to have permission to pick up the camper.
  - (9) A transportation plan for limited camp transportation, if needed, provided that transportation conforms with the guidance in Section 10, Transportation.
  - (10) Camps must have contingency plans for arranging for transportation for a sick camper, in the case that parents are unable to pick up their children, and for staff, in case they are unable to transport themselves.
- C. Preparing for Recreational Camps and Programs: Recreational Camps and Programs permitted to operate during the current phase must prepare the camp environment to promote the new health and safety requirements and to facilitate infection control activities.
- (1) Contact facility management and other programs sharing facility space to discuss if and how new requirements can be implemented and plan to address any challenges.
  - (2) Prepare the materials and equipment to be used by children to minimize sharing and promote physical distancing. Shared items that cannot be cleaned or disinfected must be removed from activity rotation.
  - (3) Prepare all cleaning, sanitizing, and disinfecting solutions and store them in a locked closet or compartment that is accessible to staff in each area of the camp, but inaccessible to campers. Ensure that supplies for hand hygiene are adequate, accessible, and placed appropriately throughout the camp space.
  - (4) Prepare the camp space to ensure physical distancing required by the phase are met.
    - (a) Camps must consider physical building capacity limitations and the total number of children anticipated to be in any one area throughout the day and during inclement weather.
    - (b) Decisions about organization of the camp space must be guided by the camp's ability to implement adequate and consistent physical distancing, especially in terms of utilization of common spaces that need to be shared by campers and staff.
    - (c) Camp enrollment must be based on the number of individuals that may be housed in an emergency. Emergency shelter occupancy shall provide 30 sq. ft per individual in order to ensure room and enforce 6-ft separation between individuals.
  - (5) Recreational Camps and Programs must increase staffing to ensure supervision of campers in the case of potential need for quarantine of staff with symptoms or illness as well as supervising youth with symptoms. Refer to [Healthcare Personnel: Occupational Exposure & Return to Work Guidance](#) for requirements on quarantine and returning to employment. Camps will also need increased staff to accommodate the rigorous cleaning requirements. Camps must make sure they are adequately staffed with health care professionals or trained healthcare supervisors to supervise symptomatic campers while also managing their other health care responsibilities.
    - (a) At a minimum, camps must ensure 2 properly trained Health Care Supervisors are present at all times at camp in the event a camper becomes symptomatic while at camp.
  - (6) Staff members age 65 or older or with serious underlying health conditions should assess their risk to determine if they should stay home or follow additional precautions.

- (7) Ensure that there are adequate provisions for the storage of children and staff belongings so that they do not touch.
  - (8) Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible by opening windows and doors, using fans, and other methods unless doing so creates a hazard.
  - (9) Ensure water systems and features (e.g., cooling systems) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.
- D. Additional Strategies to Reduce the Risk of Transmission for Recreational Camps and Programs: In addition to the guidance included in Section 9, Recreational Camps and Programs must follow the guidance below.
- (1) Camp cohorts may not exceed maximum group size in place at the time of operations. Cohorts must not be combined at any time.
    - (b) The same staff member must be assigned to the same group of children each day for the duration of the program session (if weekly or monthly) and at all times while in care.
  - (2) Staff must not float between groups either during the day or from day-to-day, unless needed to provide supervision of specialized activities such as swimming, boating, archery, firearms, and in these situations must adhere to social distancing requirements.
  - (3) Camps may not congregate staff/campers in a way that does not allow for six feet of social distancing between individuals.
  - (4) Staff should limit their contact with one another unless they are in the same cohort. Staff meetings should be conducted remotely, when possible.
  - (5) Camps may need to stagger the use of communal spaces in order to ensure physical distancing requirements. For example, camps must add extra meal shifts if necessary to maintain social distancing and maximum group sizes in the dining hall or dining area.
  - (6) Camps must monitor all individuals that staff and children come into contact with during the course of the camp day in the potential case of exposure.
  - (7) While all camps serving youth and children must designate an isolation room or space, camps must prepare for the possibility of needing to isolate multiple campers. If possible, camps must create multiple, separate isolation rooms and spaces so symptomatic individuals can also social distance from each other.
- E. Activity Limitations for Recreational Camps and Programs: All activities must be conducted in accordance with social distancing, masking and sanitation requirements and following the guidance below.
- (1) Minimize equipment sharing, and clean and disinfect shared equipment (such as balls and pucks) and at the end of each activity by products recommended by the CDC. Personal equipment, such as helmets and pads, shall not be shared.
  - (2) Activities should be outside when possible.
  - (3) Camps can use own swimming pools and beach front in accordance with [guidance](#). Camps may not use community pools or beaches.
  - (4) Campers must use their own dedicated personal floatation devices which camps may provide. Camp operators that supply Personal Floatation Devices (PFD) to campers must clean and disinfect the PFD in accordance with [US Coast Guard guidance](#).
  - (5) Camps may not take campers on field trips or for other offsite travel.

## Considerations for Future Phases

We understand that these requirements limit many providers from reopening in earlier phases and appreciate the continued commitment in the field to health and safety. As the Commonwealth prepares for a phased reopening, there are several considerations with respect to child and youth serving summer programs. It is critical that health and safety protocols are in alignment with the latest guidance from public health experts and informed by data. Prior to any changes in protocols, localities must meet the required thresholds as determined by public health experts to ensure a safe transition to lessened restrictions.

While most states are still considering what a phased reopening of child care looks like and what public health indicators can trigger relaxing of restrictions, initial guidance has been issued. This guidance suggests lessened restrictions in future phases could be structured as follows:

1. Allow minimal mixing between groups within programs.
2. Increase maximum group size.
3. Resume use of some toys and materials within programs, including cloth toys, if programs are able to clean and sanitize them daily.
4. Allow for activities with limited contact and with shared equipment that can be cleaned / disinfected between users
5. Allow offsite travel if social distancing, handwashing and cleaning/disinfecting requirements can be met.
6. Allow for use of community pools, beaches, parks and playgrounds that meet sanitation and social distancing [requirements](#).
7. Allow Recreational Day Camps and Programs to operate with expanded activities.
8. Allow residential camps to operate with specific guidelines. See below for additional considerations.
9. Allow programs to operate with expanded activities and adjusted group sizes. (May be considered in Phase 4.)
10. Allow offsite travel and field trips. (May be considered in Phase 4.)

The following protocols must continue in future phases, per [CDC guidance](#):

1. Promoting healthy hygiene practices.
2. Intensifying cleaning, disinfection, and ventilation.
3. Limiting sharing.
4. Checking for signs and symptoms.
5. Planning for when a staff member, child, or visitor becomes sick.
6. Maintaining healthy operations.

**Note:** Residential camps and overnight stays may be permitted to open in a later phase as more data becomes available. Residential camps will be required to adhere to all requirements outlined in this document, as well as to the requirements below, which may be updated and expanded.

- (1) Pre-camp screening should be conducted for all campers and staff and must include a pre-screen of health history forms to identify who may be at higher risk for communicable diseases, including COVID-19. Opening Day and daily screening at the beginning of each day of both campers and staff must be conducted including an assessment for symptoms and fever.
- (2) Each cohort of campers and staff should share the same sleeping areas and remain together for all activities in order to reduce the number of contacts.
- (3) Residential camps must make sure camper beds are at least 6 feet apart, and youth and staff are able to remain at least 6 feet apart while sleeping. Bunk beds are not permitted unless only one camper (one of the bunks is empty) is in each bunk bed.
- (4) Residential camps must provide laundry services. The CDC recommends cleaning bed sheets, pillow cases, mattresses, and cots weekly. Cloth face coverings must be cleaned at least daily and whenever soiled. Children's belongings, including clothes, bed linens, electronics, toys and other items must be regularly cleaned.
- (5) Residential camps must plan for the possibility that in the case of exposure, they will need to clean affected area(s), which could include sleeping cabins, bathrooms, and dining halls, including having additional space to safely keep individuals while the area is closed off for 24 hours and then being cleaned.
- (6) Residential camps must prohibit non-essential visitors opting for video conferencing and telehealth options as much as possible.
- (7) Designate one central point of entry to the residential camp and maintain a record of all individuals, including any employees, staff, and contracted service providers who provide care. Post signage at all entrances and leave notice that anybody with fever or other potential COVID-19 symptoms must not enter.
- (8) Residential camps must ensure that campers and staff are aware of infection control practices, including proper handwashing, wearing and removing masks, and that personal supplies (e.g., hats, brushes, hair ties, contact solutions) and drinking containers must never be shared with others.
- (9) Requirements for counselors to remain on camp grounds during days off is under consideration.

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