

GUIDANCE for HEALTH CARE PROVIDERS on CHILD/YOUTH with COVID-19

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Objectives

- Establish a standardized regional understanding, guidance, and response to COVID-19 for Child/Youth
- The development of a clinical integrated pathway is intended to inform paediatric healthcare providers on the care of the Child/Youth with suspected or confirmed COVID-19.
- The development of a community parent pathway is intended to inform parents/caregivers on the steps required when a child fails COVID-19 Screen.

Background Child/Youth and COVID-19:

As of September 16, 2020, Canada reports 13,164 COVID-19 cases or 9.5% distribution of cases in age group 19 or younger with Ontario reporting 3257 cases of COVID-19 for the same age group.¹ While there is a lower reported case count when comparing Child/Youth to adults, true incidence of COVID-19 infection in Child/Youth is unknown.

Close contact with an affected adult family member or proximity to a high population of cases are the most common vectors for Child/Youth COVID-19 infection.² Early and ongoing data suggests while viral loads in Child/Youth are similar to those in adults, evidence of extensive paediatric transmission has not surfaced.^{3,5,6} While newer data, gleaned from an overnight camp in United States, demonstrated infection rates ranging of 33%, 44%, and 51% across Child/Youth aged 6-10, 11-16, and 18-21 respectively⁴, it is important to consider the data in the context of a congregate living setting where elevated transmission rates are anticipated. Additionally, while clear evidence exists supporting adult to child transmission, analysis suggesting child to adult transmission remains lacking.^{3,5,6} Finally, using mathematical modeling, vast social distancing practice and high adoption of facial coverings have been demonstrated as excellent transmission reduction strategies.^{7,8}

The incubation period of COVID-19 in Child/Youth is approximately 2 days with a range of 2-10 days (similar to adults) with symptoms similar to other illnesses including influenza, streptococcal pharyngitis, and allergic rhinitis.^{2,6} Evidence strongly suggests that the vast majority of COVID-19 infected Child/Youth experience mostly mild symptoms or could be asymptomatic.^{2,6} Case definitions of COVID-19 are available through the Ministry of Health website at

http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_case_definition.pdf.

Overall prognosis for COVID-19 appears to be better for Child/Youth compared to adults, but it will be important to continue diligent surveillance of Child/Youth as the pandemic progresses and cases rise as information may change. Child/Youth rates of COVID-19 hospitalization are significantly lower than in adults with few Child/Youths becoming critically ill.^{3,9-11} A JAMA Paediatrics study, across North America, followed 48 PICUs admitted COVID-19 Child/Youths, aged newborn to 21 years, in March and April. More than 80 percent had chronic underlying conditions, such as immune suppression, cardiac, obesity, diabetes, seizures or chronic lung disease. More than 20 percent experienced failure of two or more organ systems due to COVID-19, and nearly 40 percent required a breathing tube and ventilator.¹⁰

The Canadian Pediatric Society issued a Public Health Alert on May 12, 2020¹² to notify health practitioners of an acute inflammatory syndrome temporally linked to COVID-19 reported in Child/Youth. Now defined as Multisystem Inflammatory Syndrome (MIS-C), Child/Youth with this condition present with symptoms of systemic inflammation, and can have clinical similarities to Kawasaki Disease, toxic shock syndrome and macrophage activation syndrome.¹²⁻¹⁵ Prominent features include fever, abdominal pain, cardiac involvement and rash, among others.¹²⁻¹⁵ There may be a spectrum of disease severity and phenotypes in Child/Youth affected by COVID-19-associated inflammation.¹²⁻¹⁵ The following preliminary case definitions from the World Health Organization¹⁶ and the Canadian Pediatric Society¹² were used in the development of the MIS-C Guide:

World Health Organization

Child/Youth 0-19 years of age with fever \geq 3 days

AND two of the following:

- a) Acute gastrointestinal symptoms (abdominal pain, vomiting, diarrhea)
- b) Rash or bilateral non-purulent conjunctivitis or muco-cutaneous inflammation signs (oral, hands, feet)
- c) Hypotension or shock
- d) Features of myocardial dysfunction, or pericarditis, or valvulitis, or coronary abnormalities (ECHO findings or elevated Troponin/BNP/NT-proBNP)
- e) Evidence of coagulopathy (abnormal PT, PTT, elevated D-dimers)

AND

Elevated markers of inflammation such as ESR, C-reactive protein, or procalcitonin

AND

No other obvious microbial cause of inflammation, including bacterial sepsis, staphylococcal or streptococcal shock syndromes and no alternative plausible obvious diagnosis

AND

Evidence of COVID-19 (RT-PCR, antigen test or serology positive), or likely contact with persons with COVID-19 case

Canadian Paediatric Society

Hospitalized patient with PIMS/MIS-C/Kawasaki Disease temporally associated with COVID-19

Persistent fever (greater than 38 degrees Celsius for 3 or more days) and elevated inflammatory markers (C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), or ferritin.

AND one or both of the following:

Features of Kawasaki disease (complete or incomplete) ·Toxic shock syndrome (typical or atypical)

AND

No alternative etiology to explain the clinical presentation

Cases of MIS-C are reportable under the Reporting Information Affecting Public Health Regulation and Public Health Act. Please contact your local Medical Health Officer to report cases of MIS-C for guidance regarding further testing required to confirm COVID19 and consider consultation with tertiary pediatric specialists.

COVID-19 Testing

Covid-19 testing remains dependent on local testing capacity and the availability of testing resources inclusive of collection devices and test reagents.

Recognizing the challenges that testing path has for Child/Youth, practitioners are encouraged to use deep nasal/midturbinare testing as the first option for Child/Youth where clinically appropriate. This test sensitivity has been demonstrated to be similar to nasopharyngeal testing and provides a better patient experience for Child/Youth.

Health Care Providers are encouraged to use their clinical judgement to assess and select the collection test type that is most appropriate for the child/youth. Midturbinare/deep nasal swab, Nasopharyngeal swab, and Oropharyngeal/Throat combined with Anterior Nares/Nostril are all preferred test collection options. Each of these preferred tests can be complete with the current swabs available. Additionally, there is no need to change a swab where initial testing was incomplete. Simply use the same swab and proceed to test collection determined most appropriate for next attempt.

For additional information on collection and testing please visit the Pathology and Lab Medicine (PaLM) site at <https://www.lhsc.on.ca/palm/>.

Opportunities for alternative COVID-19 testing techniques are actively being investigated and literature surveillance on saliva testing is encouraged as this may provide a significant increase in alleviating resistance to testing in Child/Youth. For optimal results during COVID pandemic, strategies that minimize discomfort, and hence increase compliance without sacrificing test sensitivity/specificity are critical. Please find the Public Health Ontario briefing on the use of alternative collection testing here <https://www.publichealthontario.ca/-/media/documents/ncov/evidence-brief/2020/08/eb-covid-19-pcr-testing-alternative-collection-testing.pdf?la=en>.

Integrated Pathway for Child/Youth with COVID-19:

In Ontario, a joint statement on reopening of schools for this fall was released on August 5th, 2020.¹⁷ Adapted from various aspects of this report, the Ontario Government has outlined procedures and plans related to back to school protocols. The evaluation of symptomatic Child/Youth who attend school will lead to a large number of new tests daily, and could impact or change the access patterns of Child/Youth and their families to their primary care practitioner, COVID assessment centres, and general and specialized paediatric emergency departments. The development of a clinical integrated pathway, and associated supporting tools, to inform healthcare providers in region on the care of the Child/Youth will help create consistency and streamline flow of patients so that the best care, for the right patient, in the right location, can occur.

Pathways

Appendix A	Health Care Practitioners Guide
Appendix B	Health Care Practitioners MIS-C Flowsheet
Appendix C	Health Care Practitioners: Symptomatic Child Flowsheet
Appendix D	Health Care Practitioner COVID-19 Test Diagram

Appendix E	Supporting Paediatric Patients for COVID-19 Testing
Appendix F	Public Health Pathway: My Child Has Failed Screening Public Health Pathway: My Child Has Been Tested for COVID-19 Public Health Pathway: My Child Has Not Completed a COVID-19 Test
Appendix G	Health Care Practitioners Guide: Paediatric Patient with Complex Health Care Needs
Appendix H	Health Practitioner Referral Guide: MIS-C

[Appendix A: Health Care Practitioners COVID-19 Testing Guide: Symptomatic Child/Youth](#)

The testing guide has been created to aid front line care workers in weighing factors that can facilitate the decision to test symptomatic school aged-Child/Youth. The guide stresses the need to have a low index to test, especially with Child/Youth who present with typical viral symptoms. It can be very difficult to differentiate between a number of viruses and COVID-19. The guide, while providing examples where alternate diagnosis can be reliably made, cautions users to monitor patients when clinical course is inconsistent with initial diagnosis.

[Appendix B: Health Practitioners Guide: COVID-19 Multisystem Inflammatory Syndrome in Child/Youth \(MIS-C\)](#)

The MIS-C guide has been provided to guide the early consideration of MIS-C by practitioners. The unexpected persistence of fever, or the development of new symptoms may guide the practitioner to recommended testing, monitor for symptoms, or refer to tertiary Child/Youth's Hospital for evaluation via the Emergency Department.

[Appendix C: Health Practitioners Guide: Symptomatic Child/Youth Flowsheet](#)

The flowsheet provides a guide that can help navigate the anticipated flow of patients to the right location. Also provided is information on self-isolation, recommendations on length of self-isolation, and the management of household contacts both prior to testing, and after testing results known. As well, guidance on what to recommend if a family refuses testing on a child is provided.

[Appendix D: Region Partner Document: LHSC/SJHC/PaLM Specimen Collection Guide – COVID-19](#)

The specimen collection guide provides visual guides to testing.

[Appendix E: Supporting Paediatric Patients for COVID-19 Testing](#)

The support tool, designed by Child Life Specialists from Children's Hospital, LHSC, provides tips for health care providers collecting COVID-19 swabs and was developed to minimize Child/Youth anxiety and discomfort during the testing.

[Appendix F: Partner Document\(s\) Return to School Decision Tree](#)

This parent/caregiver decision tree provides clear direction on My Child pathways that include: failed screen, positive COVID-19 test results, symptomatic child without testing, and return to school guidance.

[Appendix G: Guide to the Care of the Paediatric Patient with Complex Health Care Needs](#)

Under consideration

[Appendix H: Health Practitioner Referral Guide: MIS-C](#)

Under consideration

References

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HEALTH CARE PRACTITIONER'S COVID-19 TESTING GUIDE: Symptomatic Child/Youth

During COVID19 Pandemic - in order to reduce spread, Public Health Recommends an extremely low threshold to test in symptomatic child/youth especially if viral illness on differential. Child/Youth can present with minimal symptoms and there is no "classic" presentation.

Common COVID-19 symptoms as per Ontario guidance: *

- fever (feeling hot to the touch, a temperature of 37.8 degrees Celsius or higher)
- chills
- cough that's new or worsening (continuous, more than usual)
- barking cough, making a whistling noise when breathing (croup)
- shortness of breath (out of breath, unable to breathe deeply)
- sore throat
- difficulty swallowing
- runny, stuffy or congested nose (not related to seasonal allergies or other known causes or conditions)
- lost sense of taste or smell
- pink eye (conjunctivitis)
- headache that's unusual or long lasting
- digestive issues (nausea/vomiting, diarrhea, stomach pain)
- muscle aches
- extreme tiredness that is unusual (fatigue, lack of energy)
- falling down often
- for young children and infants: sluggishness or lack of appetite

Would test unexplained changes in behaviour in young children / infants

Would test any **documented** fever - **

Would not test on chills alone

Would test any new onset cough of > 4 hrs duration OR croupy sounding OR evidence of SOB

Would not test short duration isolated sore throat, mild difficulty swallowing in isolation with no physical findings if < 24 hrs

Would test new onset runny nose unless strong consistent allergy history

Would test any changes to taste/smell

Would test any acute conjunctivitis unless allergic conjunctivitis

Would not test isolated headache unless >12 hrs

Would test any digestive issues consistent with viral gastroenteritis but NOT isolated stomach ache, or isolated short duration episodes of vomiting

Would not test isolated muscle aches unless part of viral prodrome

Would not test isolated fatigue unless part of viral prodrome

* Would not test from symptoms above if entirely consistent with known chronic conditions and responds as expected

** Fever without a clear source, Can use discretion to not swab patients with a confident diagnosis of one these **non-respiratory infections**,
- convincing dip-positive UTI (if culture negative and fever persisting consider re-evaluation ex. sterile pyuria MIS-C)
- Rapid Strep Test +ve exudative tonsillitis or scarlet fever syndrome (persistent fever should trigger COVID testing)
- cellulitis or abscess
- swab proven chickenpox or shingles

*** New acute gastrointestinal symptoms not explained by an obvious alternate diagnosis. Can use discretion to not swab patients with a confident alternate diagnosis, example: isolated vomiting with head injury, vomiting, abd pain resolving after treatment of anaphylaxis, or intussusception, poisoning, culture-positive bacterial gastroenteritis, etc

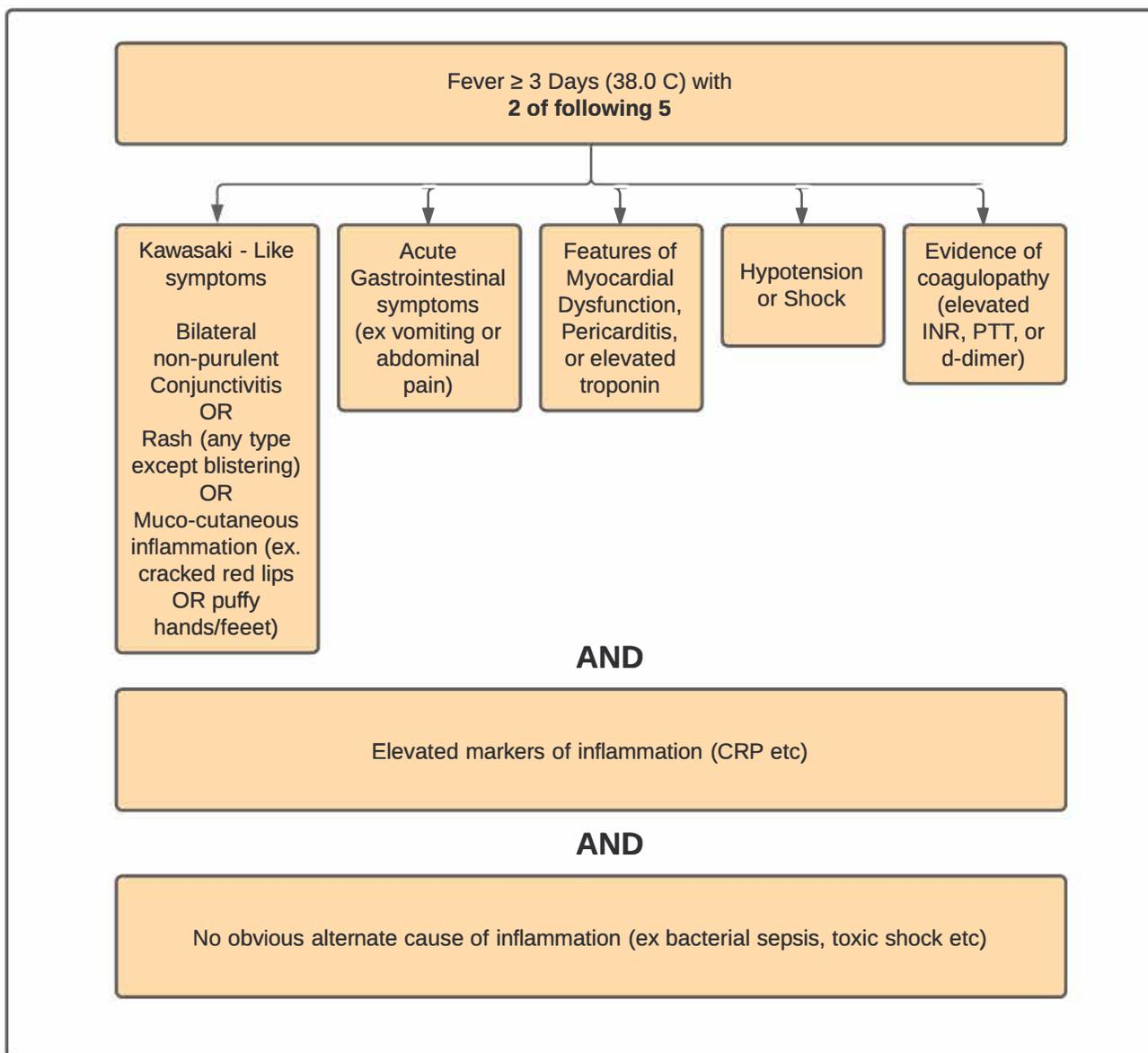
Patients presenting with >5 days of unexplained fever should be referred to a Children's Hospital Emergency Department for Multisystem Inflammatory Syndrome in children (MIS-C) evaluation.
Patients with >3 days of fever with some symptoms consistent with Kawasaki Disease, GI or Neurologic complaints should be referred as well

- Decisions to pursue further testing in **Child/Youth with ≥3 days of fever** may be guided by a number of factors:
- 1) presence of symptoms consistent with Kawasaki Like symptoms, Acute GI symptoms or features of myocardial dysfunction
 - 2) child/youth's appearance - well vs unwell
 - 3) disease prevalence in your community in recent weeks (MIS-C presents 3-6 weeks following peaks in COVID-19 infections)

Childr/Youth presenting with >5 days of unexplained fever should have further evaluation and/or be referred to a Children's Hospital Emergency Department for comprehensive assessment including Multisystem Inflammatory Syndrome in children (MIS-C).

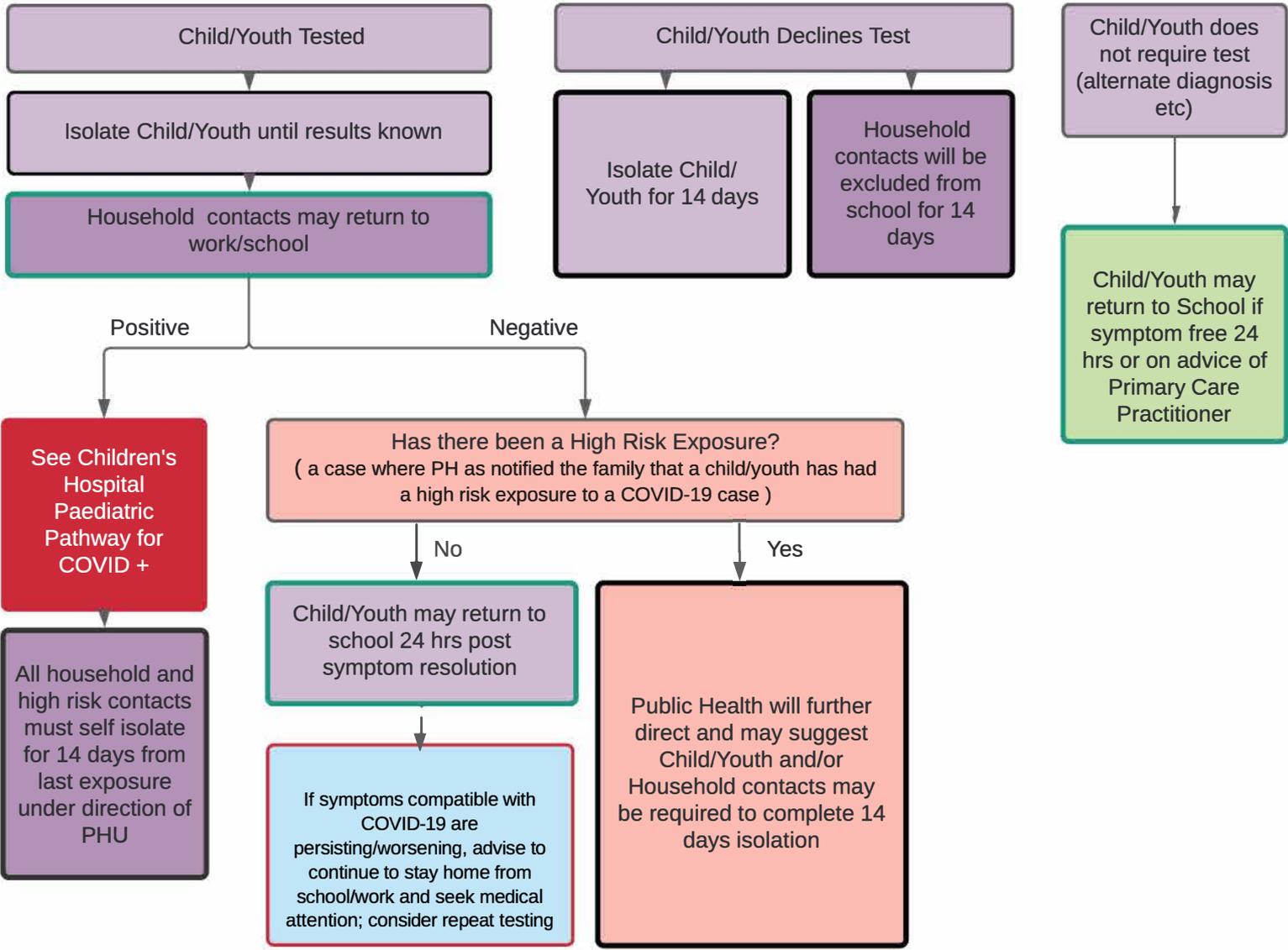
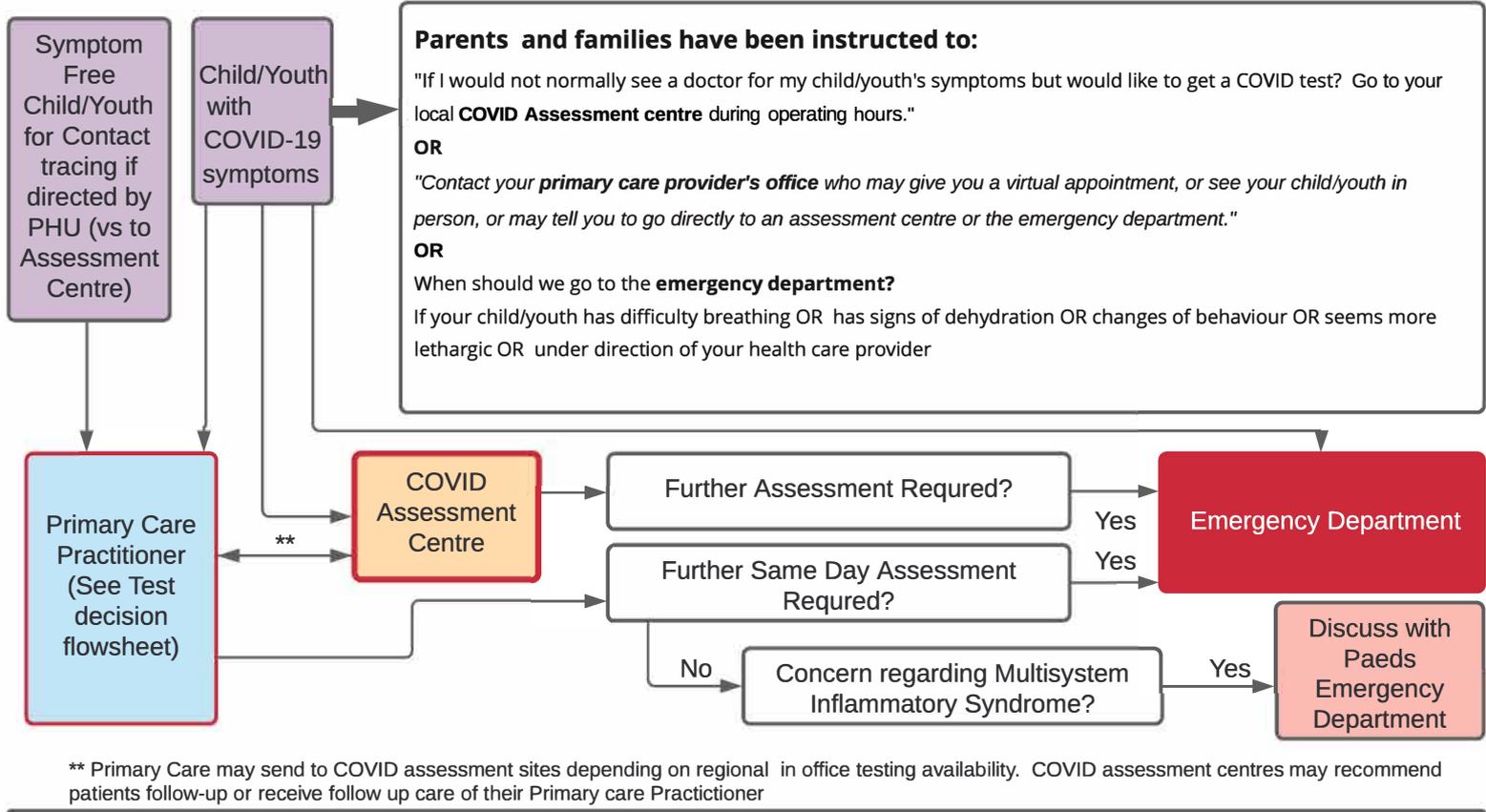
Vigilance for this serious but uncommon disease is important. **Child/Youth with alternate diagnosis but not responding to therapy should prompt reevaluation.**

Consideration of MIS-C associated with COVID-19 in the community



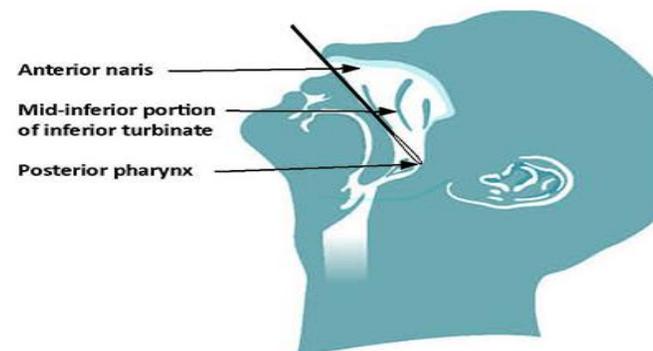
Refer to regional Children's Hospital for evaluation via Emergency Department.
 If Patient critical, please contact via
 Critical 1-800-668-4357 (HELP)

For more detailed information on MIS-C/PIMS, refer to the Canadian Pediatric Society practice point on this topic.
<https://www.cps.ca/en/documents/position/pims>



Nasopharyngeal swab – Preferred specimen type

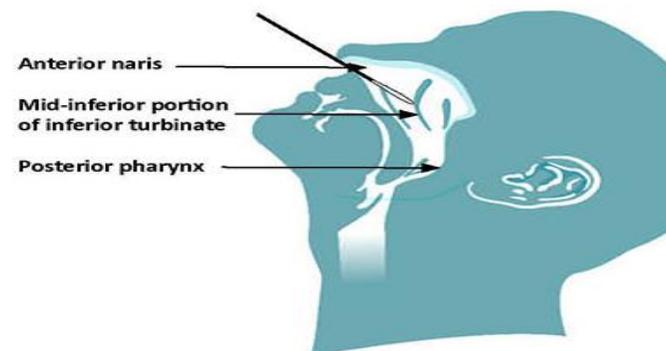
1. Tilt the patient's head back 70°.
2. Insert a flexible swab through the nares parallel to palate (not up) until:
 - A. Resistance is met, OR
 - B. Distance is equivalent to half the distance from the patient's ear to their nostril.
3. Gently rub and roll the swab.
4. Leave the swab in place for several seconds to absorb secretions
5. Slowly remove the swab while rotating it and immediately place in sterile tube containing transport medium.



In a seated position, tilt the head back at a 70° angle as illustrated in the picture

Mid-Turbinate/Deep Nasal Swab - Preferred when NP swab cannot be collected

1. Tilt the patient's head back 70°.
 2. While gently rotating swab, insert swab about 2.5cm (> 1 in.)* straight back (not up) into nostril until the collar/safety stopping point touches the outside of the nose.
 3. Rotate swab several times against the wall.
 4. Leave swab in place for several seconds to absorb secretions
 5. Repeat for both nostrils using same swab
 6. Immediately place in sterile tube containing transport medium
- *Pediatrics: swab insertion distance will differ for pediatric patients



In a seated position, tilt the head back at a 70° angle as illustrated in the picture

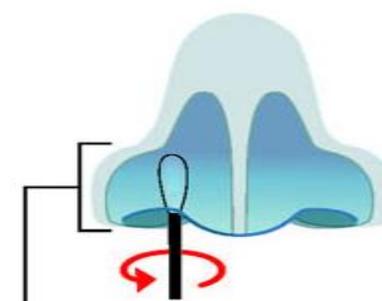
Oropharyngeal/Throat combined with Anterior Nares/Nostril -Preferred when NP swab cannot be collected

1. Insert swab in posterior pharynx and tonsillar areas
 2. Rub swab over posterior pharynx and bilateral tonsillar pillars; avoid tongue, teeth and gums
 3. Using the same swab, insert about 1cm (0.5in) inside nares.*
 4. Rotate swab and leave in place for 10-15 seconds.
 5. Using the same swab, repeat for the other nostril
 6. Immediately place in sterile tube containing transport medium
- *swab insertion distance will differ for pediatric patients.

Steps 1-2



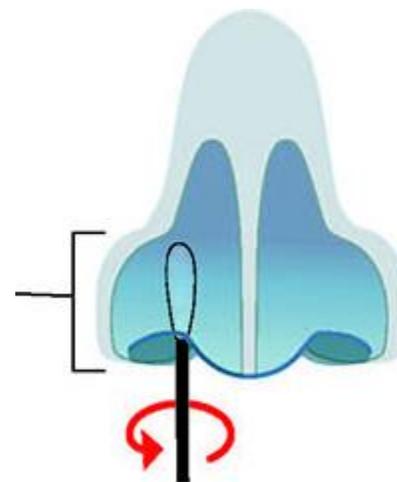
Steps 3-5



Anterior Nares/Nasal/Nostril Swab (Both Sides) – Acceptable but less sensitive than NP, Deep Nasal, or combined Throat and Nasal Swab specimens

1. Insert swab about 1 cm (0.5 in) inside nares*.
2. Rotate swab and leave in place for 10-15 seconds.
3. Using the same swab, repeat for other nostril.
4. Immediately place in sterile tube containing transport medium.

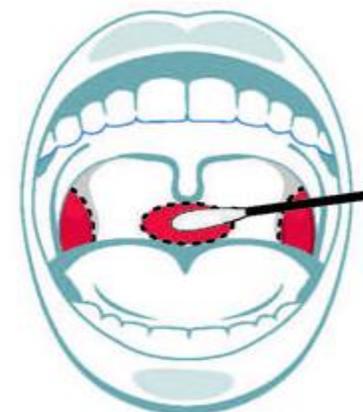
*Pediatrics: swab insertion distance will differ for pediatric patients



Throat/Oropharyngeal Swab – Acceptable but less sensitive than NP, Deep Nasal, or combined Throat and Nasal Swab specimens

1. Insert swab in posterior pharynx and tonsillar areas
2. Rub swab over posterior pharynx and bilateral tonsillar pillars; avoid tongue, teeth and gums
3. Immediately place in sterile tube containing transport medium

Steps 1-2



A Child Life guide for Health Care Providers



Create Comfort

For pediatric patients, you can create comfort from the moment you introduce yourself all the way through to the end of their visit. You can do this by:

- (1) Remember to **lower yourself to the child's level** by sitting or kneeling
- (2) Introduce yourself! Children benefit from knowing what **your name** is & **how you will help them**.
- (3) Get to know your patient through lighthearted questions or playful interactions
- (4) Always **use upright comfort positioning** for procedures.



Provide Preparation

All patients, but especially children, need to be prepared for procedures to reduce anxiety and mitigate trauma. The best preparation always includes

- (1) **Why** the test needs to be done.
- (2) **What the test will feel like**, compared to something the child can relate to
- (3) What the child **is expected to do** (i.e. hold still)
- (4) Things they can do to **cope**.

You have come to visit us today because you are not feeling well. Inside your nose, at the very back there are germs that live there. The test picks up some of those germs and we send the germs to a scientist. They can tell us more information about your body.

To pick up the germs, I am going to use this soft, bendy, Q-Tip to touch the back of your nose. Some kids say that it feels tickly; like when you get water up your nose or drink a fizzy drink. You can help with the test by keeping your head a still as a statue!

Lots of kids like to sit on their parent's lap for the test. Would you like to? Some kids feel a little bit nervous, especially if its their first time and that's OK! If you are, it helps to take a deep breath.

Let's do this together. When I count to three, I want you to close your eyes and we will count together all the way to 5.
1-2-3-4-5
All done.



Give Appropriate Choices

Choices for this procedure should include:

- (1) Would you like to sit with your parent or by yourself? On the bed or in a chair?
- (2) Would you like to watch me, or close your eyes?
- (3) Would you like me to count before or during?
- (4) You can squeeze your parent's hand, give your stuffy a hug or take a deep breath in.



Try to AVOID

- **Multiple staff members talking** during a procedure. This is overwhelming
- **Reassurance** Using statements of "it's okay", "you're fine" can increase anxiety. Instead try "you are safe, this feeling will pass, we're here with you."
- **Comparing children** to others; this can create shame and self-doubt
- **Losing patience**; ask for help from a partner or switch out.

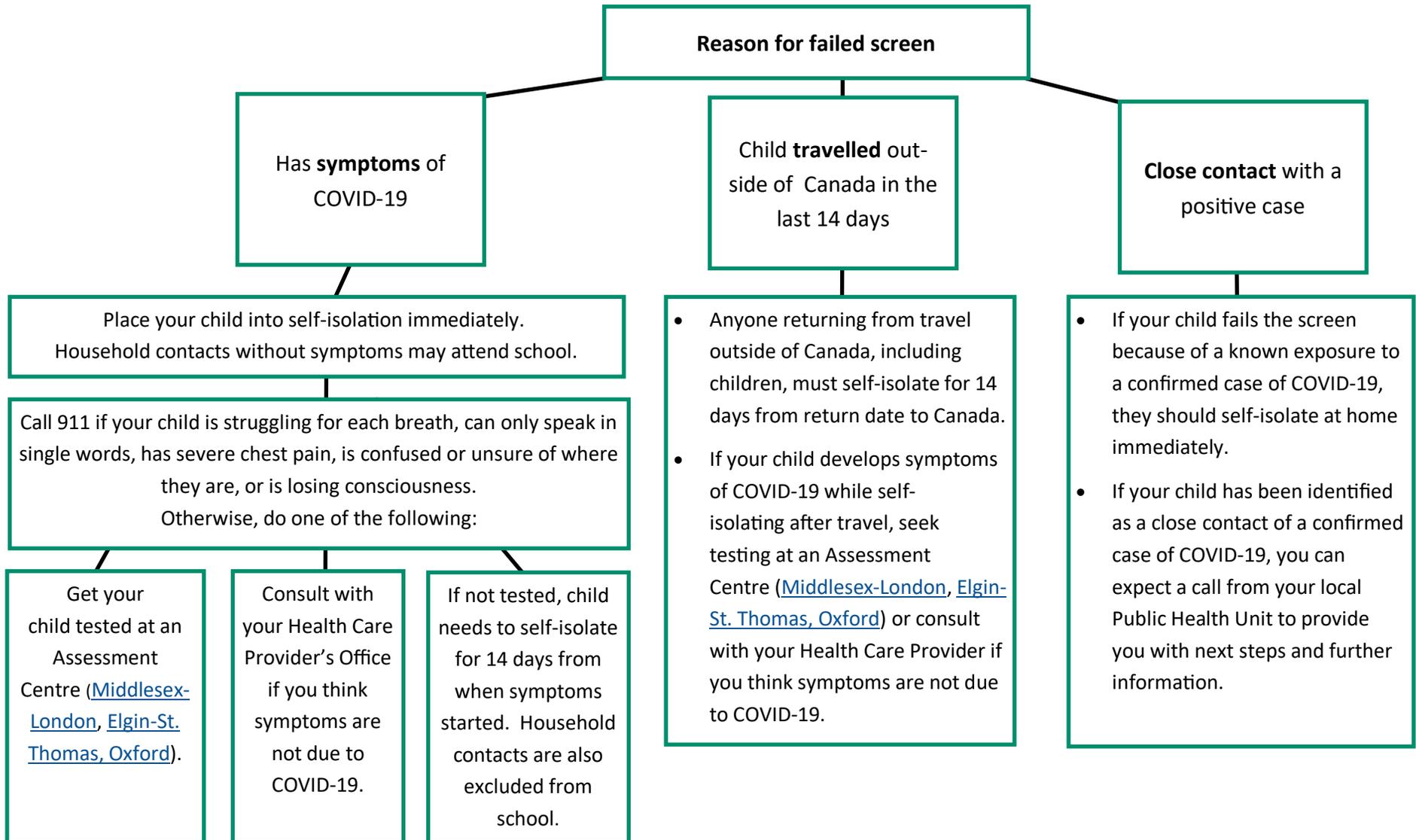


Promote Resilience

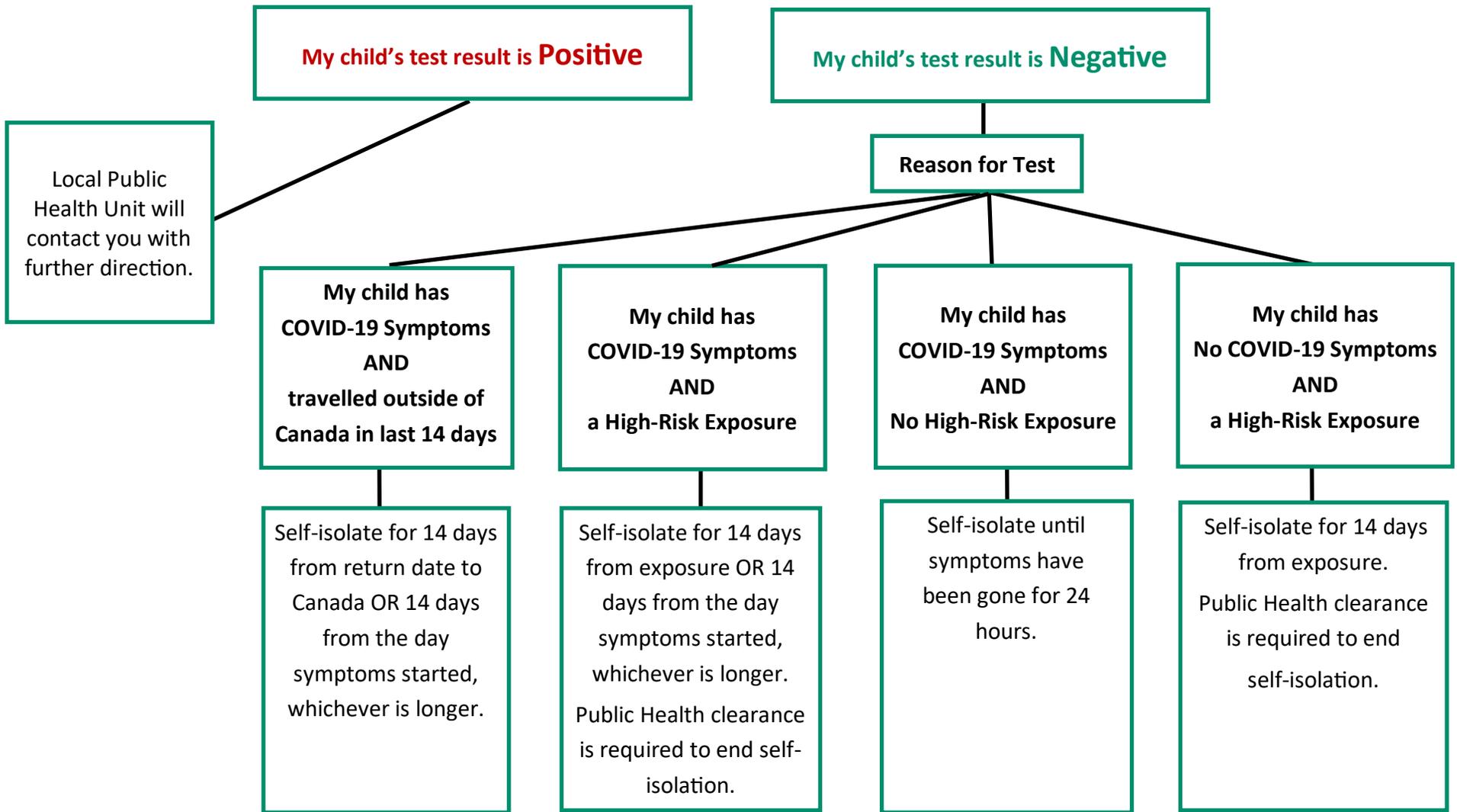
Share with children what they did well! It could be holding still, counting or doing deep breaths OR if they were very nervous, having courage.

If the child is distressed, stay until they calm or follow up once they have.

My child has failed the daily screen and cannot go to school. What should I do?



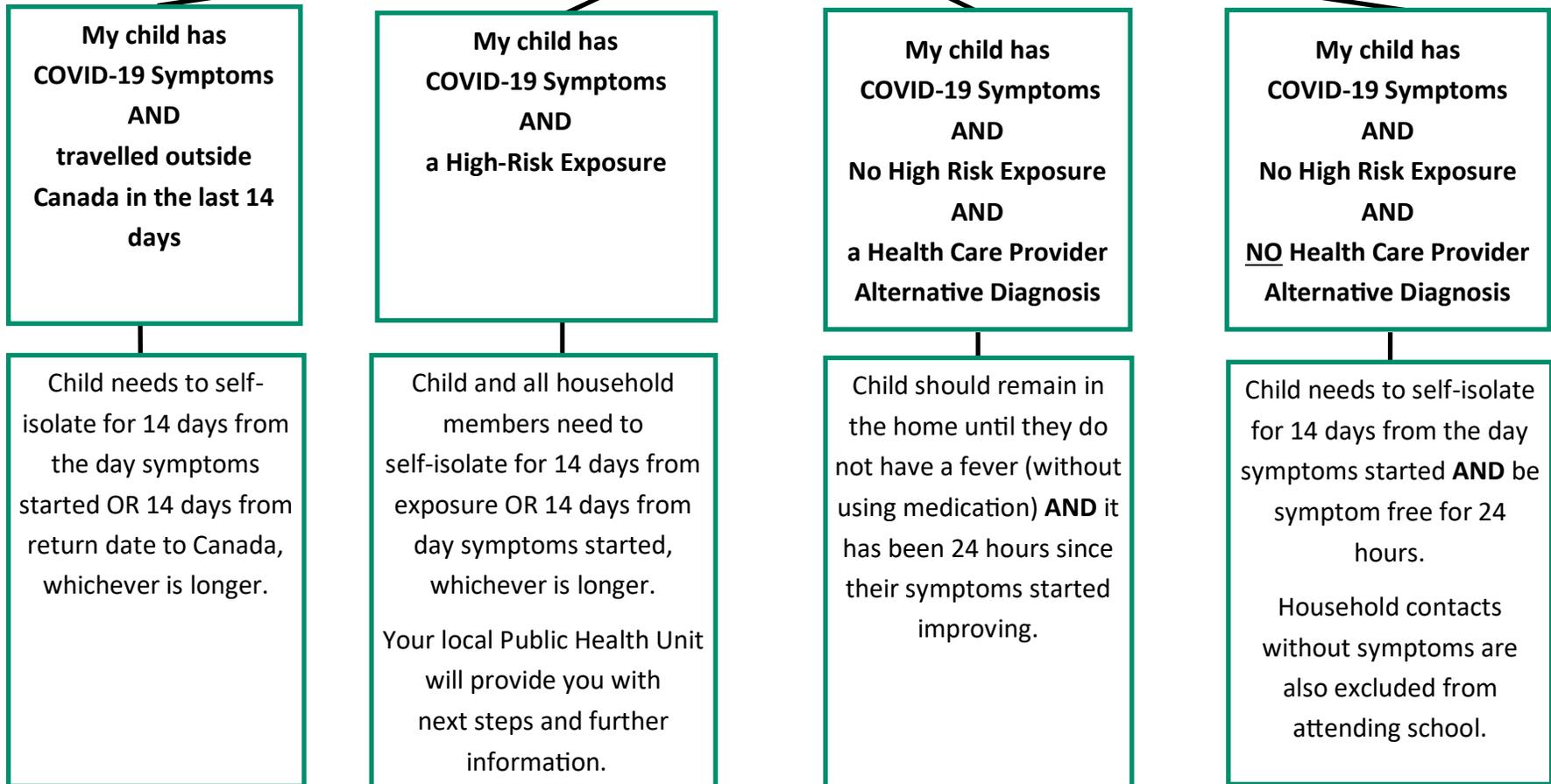
My child has been tested for COVID-19. When can they return to school?



High Risk Exposure is defined as: Close contact with a positive case of COVID-19 as determined by public health.

My child has symptoms but did not get tested for COVID-19. When can they return to school?

My child has NOT completed a COVID-19 test



High Risk Exposure is defined as: Close contact with a positive case of COVID-19 as determined by public health.