HEALTH & SAFETY GUIDELINES

for Child Care and Early Education Operating During COVID-19

AUGUST 14, 2020

OREGON DEPARTMENT OF EDUCATION
EARLY LEARNING DIVISION

Oregon Health Authority

Health and Safety Guidelines for Child Care and Early Education Operating During COVID-19

Early Learning Division,
Oregon Department of Education

VERSION 1, Published August 14, 2020

For more information and the latest updates, visit https://oregonearlylearning.com/COVID-19-Resources.

Questions? Email ProviderContact@state.or.us.

If you need accommodations with any sections (visuals, tables, etc.), please contact us by email ProviderContact@state.or.us, or phone 1-800-556-6616.

Contents

Introduction **04**

Purpose 04

Applicability, Organization, Effective Date and Source of Authority 04

Development of Guidelines 05

Current COVID-19 Context 06

Primary Methods to Reduce Spread in Child Care and Early Education Programs 09

Equity 12

1. Drop-Off and Pick-Up **15**

2. Daily Health Check **17**

3. Recordkeeping **21**

4. Family Engagement **23**

5. Group Size and Stable Groups **26**

6. Personal Protective Equipment for Children and Adults **32**

7. Daily Activities **36**

8. Handwashing and General Hygiene **39**

9. Food and Nutrition **41**

10. Cleaning and Building Maintenance **43**

11. Responding to Possible and Confirmed Cases of COVID-19 **52**

12. Transportation **56**

13. Professional Development **59**

14. COVID-19 Health and Safety Plan **62**

Introduction

Purpose

The purpose of Health and Safety Guidelines for Child Care and Early Education Operating During COVID-19 (replacing Safety Procedures and Guidance for Child Care Facilities and Other Early Learning Programs Operating During COVID-19) is to address policies and practices in child care and early education programs that ensure safe operations, and help reduce the transmission of COVID-19. Safe and quality child care and early education is fundamental to the state's recovery efforts, and the short- and long-term well-being of children and families.

Safe and quality child care and early education is fundamental to the state's recovery efforts, and the short- and long-term well-being of children and families.

In issuing these guidelines, the Early Learning Division (ELD) and the Oregon Health Authority (OHA) are seeking to support the availability of essential child care and early education services while also protecting the health and well-being of staff, children, and families. Initial guidance was first released in spring 2020. This revision reflects ongoing developments regarding COVID-19, such as increased scientific understanding of the most effective strategies for reducing the risk of transmission and the continued presence of COVID-19 throughout Oregon. As the situation regarding COVID-19 evolves, and new information is available, ELD and OHA expect to revisit these guidelines and update accordingly.

Applicability, Organization, Effective Date and Source of Authority

Applicability

The guidelines are required for each of the following types of child care and early education programs:

- All licensed programs, including Certified Center (CC), Certified Family (CF), and Registered Family (RF).
- All child care and preschool provided in public school settings.
- All Recorded Programs, including school-age.
- Oregon Pre-Kindergarten (Prenatal to Kindergarten), Preschool Promise, and Baby Promise.
- Oregon Relief Nurseries.
- Early Intervention and Early Childhood Special Education (EI/ECSE) provided in a child care or early education setting.

The guidelines are intended to be helpful for individuals who provide Family, Friend and Neighbor care but they are not required to be implemented in these settings.

Organization

The guidelines are organized into 14 sections. Within each section, requirements are discussed first and recommendations, which are optional, follow.

Effective Date

This version of the guidelines **takes effect on September 1, 2020.** Any child care and early education provider may elect to implement earlier but must implement the guidelines in full if choosing to do so.

Source of Authority

There are two sources of authority for these guidelines. The first is the authority of the Early Learning Division to regulate child care through licensing, as specified in ORS 329A.250 – ORS 329A.992. The second is the authority of the Early Learning System Director, pursuant to Executive Orders 20-08, 20-12, 20-19, 20-20, and 20-25, to issue Temporary Orders as a necessary response to developments in the COVID-19 State of Emergency.

Development of Guidelines

This revision to the guidelines was informed by a robust stakeholder engagement effort, which included:

- Provider and parent/caregiver surveys that yielded more than 400 and 3,000 responses, respectively.
- Parent and provider comments on the discussion draft from approximately 1600 people—about 50% parents and 50% providers—as well as AFSCME.
- Multiple input sessions with large groups of child care providers, including weekly calls by provider type in English and Spanish.
- Small group sessions with culturally specific providers, parents, school districts, and other key stakeholder groups.
- Review and discussion with the Governor's Healthy Early Learning Council, consisting of over 40 elected officials, child care providers, early learning providers, public health experts, and parents, all appointed by Governor Brown.

Other sources of information that informed this version of the guidelines includes:

- Information from the Frequently Asked Questions related to ELD's current health and safety guidance.
- OHA guidance.
- Current Centers for Disease Control and Prevention (CDC) guidance.
- Oregon Department of Education's Ready Schools, Safe Learners guidance.
- Child care licensing requirements.
- Caring for Our Children, 4th Edition, National Health and Safety Performance Standards
- Current research on COVID-19.
- Guidance from other states.

The revised version of the guidelines took into account the following:

- The science of COVID-19.
- The science of child development.
- Cost and burden to families, child care and early education programs, and child care and early education staff.
- Experiences and perspectives of families and of child care and early education providers.
- Racial, cultural, linguistic and other systemic inequities that impact child care and early education.
- The historically under-resourced conditions of child care and early education programs.
- The importance of simplicity, transparency, and ease of administration.

Current COVID-19 Context

Oregon children and adults are both impacted by COVID-19, which has implications for the safe operations of child care and early education, the staff who work in these programs, and the children and families who depend on them.

Currently, the disease is not well controlled across Oregon. In March and April, Oregon's new case rates were high, but by May, the case rate fell to less than 1 new case per 100,000 people per day statewide. By July, the new case rate rose to 6.9 cases per 100,000 people per day statewide.[1]

Oregon children and adults are both impacted by COVID-19, which has implications for the safe operations of child care and early education, the staff who work in these programs, and the children and families who depend on them.

The Oregon Health Authority has also started reporting COVID-19 cases associated with child care and early education programs. During June and July, Oregon Health Authority identified three outbreaks with five or more cases of children and adults associated with a child care center with an enrollment greater than 30 children. As of August 3, the Early Learning Division is aware of 59 Emergency Child Care Facilities, including centers and homes, where there has been at least one case of COVID-19 and where the facility provided a voluntary report to the Office of Child Care.

The Governor, the Oregon Health Authority, and the Oregon Department of Education recently announced metrics at the county level to guide school district decisions about when it is safe to resume in-person instruction, and when a transition to comprehensive distance learning is necessary. These metrics set benchmarks for the disease spread in a community at fewer than 30 cases per 100,000 over 7 days, and a test positivity of 5% or less over 7 days in the county before a school district could offer in-person instruction in Kindergarten to 3rd grade. As of August 3, only 11 counties met these metrics.

Risks for Children and Adults

Children and youth are less likely to contract COVID-19 than adults. The rate of COVID-19 in Oregon is most concentrated in adults between 20 and up to age 60. But children are not exempt. Younger children age 0 to 9 make up 3.9% of the cases and children and adolescents age 10 to 19 currently constitute 8% of the cases (Oregon Health Authority, July 2020).

While all children are capable of getting the virus that causes COVID-19, younger children do not become sick as often as adults, and rarely experience severe illness with COVID-19. One exception is multisystem inflammatory syndrome (MIS-C)[2], a serious condition in children associated with the COVID-19 virus, where different body parts can become inflamed. In Oregon, as of August 3, 2% or less of children under 19 diagnosed with COVID-19 were hospitalized due to COVID-19, and there has been one documented case of MIS-C.

According to the report from the National Academies of Science, Engineering and Medicine, *Reopening K-12 School During the COVID-19 Pandemic Prioritizing Health, Equity, and Communities*, "evidence to date suggests that children and youth (age 18 and younger) are at low risk of serious, long-term consequences or death as a result of contracting COVID-19."[3] In the case of infants, however, there are some limited studies suggesting that infants (less than 12 months of age) may be at higher risk for severe illness from COVID-19 compared with older children.[4] And, more data is needed to understand whether underlying or complex medical conditions put children at greater risk. According to the CDC, "some data on children reported that the majority who needed hospitalization for COVID-19 had at least one underlying medical condition. The most common underlying conditions reported among children with COVID-19 include chronic lung disease (including asthma), heart disease, and conditions that weaken the immune system."[5]

There is growing literature examining children's role in spreading the disease. A large-scale study in South Korea found that children age 0 to 9 were less likely to spread the virus to their household members than older children or adults.[6] A new study in the Journal of American Academy of Pediatrics offers a similar conclusion that children are not the source of infection and that children most frequently acquire COVID-19 from adults, rather than transmitting it to them.[7] While these studies suggest that children under the age of 10 are less likely to transmit COVID-19, other studies[8] have suggested that child to adult transmission can occur; as such, the evidence remains inconclusive as of August 3 (Oregon Health Authority, July 2020).

While much of the concern about risk of contracting COVID-19 has focused on older adults, due to the severity of the illness for them, younger adults represent higher case counts in Oregon. Since January of this year, adults age 20 to 29 made up 22% of adults in Oregon who contracted COVID-19 with adults age 30 to 39 representing the next highest group (18%). In fact, rates in Oregon decreased the older the adult, with less than 10% of COVID-19 cases among adults between age 40 to 80+.[9]

There is also a clear disparity in the incidence of COVID-19 for Black, Indigenous, and People of Color (BIPOC). Oregon Health Authority data separated by certain race and ethnicities show that the rate per 10,000 for white Oregonians is 12 per 10,000 compared to 54.7 per 10,000 for Black Oregonians; 47.4 per 10,000 for American Indian and Native people; and 189.6 per 10,000 for Pacific Islander Oregonians. Latinx Oregonians (of any race) are getting COVID-19 at a rate of 69.9 per 10,000 compared to a rate of 14 per 10,000 for non-Latinx Oregonians (July 2020).

Older adults, BIPOC, and adults with underlying medical conditions are at higher risk for hospitalization, severe illness, and even death due to COVID-19. According to the CDC, age increases the risk for severe illness from COVID-19. For example, people in their 50s are at higher risk for severe illness than people in their 40s. The greatest risk for severe illness from COVID-19 is among those age 85 or older. In Oregon, data on the percentage of adults hospitalized due to COVID-19 demonstrates risk factors surrounding age. Adults age 60 to 69 are hospitalized at nearly triple the rate than adults age 40 to 49 (Oregon Health Authority, 2020). COVID-19 mortality is higher in people with underlying medical conditions and for adults age 85 and above.[10] The COVID Racial Data Tracker (a collaboration that includes the Boston University Center for Antiracist Research) tracks up-to-date data on COVID-19 among BIPOC communities in the United States. These data have documented that nationwide Black people are dying from COVID-19 at 2.5 times the rate of white people.[11]

The underlying medical conditions that are known to increase the risk of serious illness due to COVID-19 are cancer, chronic kidney disease, chronic obstructive pulmonary disease, immunocompromised state

(weakened immune system) from organ transplant, obesity (body mass index of 30 or higher), serious heart conditions, sickle cell disease, and type 2 diabetes. People with disabilities are not inherently at higher risk for infection or severe illness from COVID-19, yet they might be at a higher risk because of an underlying medical condition.[12]

There is also emerging data that suggests pregnant women are at increased risk for severe illness due to COVID-19. One study looked at reproductive-aged women with SARS-CoV-2 infection, finding that pregnancy was associated with hospitalization and increased risk for intensive care unit admission, and receipt of mechanical ventilation, but not with death.[13] This same study found that Latinx women appear to be disproportionately affected by SARS-CoV-2 infection during pregnancy.

Spread of COVID-19

According to the World Health Organization, the "current evidence suggests that COVID-19 spreads between people through direct, indirect (through contaminated objects or surfaces), or close contact with infected people via mouth and nose secretions. People with the virus in their noses and throats may leave infected droplets on objects and surfaces when they sneeze, cough on, or touch surfaces, such as tables, doorknobs, and handrails. Other people may become infected by touching these objects or surfaces, then touching their eyes, noses, or mouths before cleaning their hands. Aerosol transmission, particularly in these indoor locations where there are crowded and inadequately ventilated spaces, and where infected persons spend long periods of time with others cannot be ruled out."[14]

Meeting the Benchmark for Increasing Group Size in Child Care

As COVID-19 cases increase in many parts of the state, the Early Learning Division is moving away from using one statewide threshold for group size in Emergency Child Care. The Early Learning Division will use the phases developed as part of Governor Brown's Reopening Oregon plan[15] as benchmarks for increasing group size to ensure the safety of adults and children in child care and early education programs. These phases indicate the prevalence of COVID-19 within a county, as well as their capacity to respond to the virus. Child care is an essential service for families and children, and one that has been open throughout the COVID-19 pandemic. Child care providers have excelled at implementing precautions related to COVID-19 and the state has not seen many cases in child care when the virus is controlled within the community at large. Therefore, these guidelines allow for increases in group sizes within child care and early education programs based on county phase.

Even though the state has seen successful implementation of precautions in child care, a benchmark is necessary to determine when the risk or increase of spread of COVID-19 within a community necessitates exercising greater caution both in child care and early education settings. The baseline phase is an indicator of this need for caution, as this phase directs Oregonians to stay home as often as possible and only go out for essential goods and services. Programs within counties in the baseline phase will not be allowed to increase group sizes beyond ten children and must prioritize essential workers. As of August 3, 2020, only one county within Oregon is in the baseline phase. Programs within counties in Phase 1 and Phase 2 are required to limit their group size for school-age children to a maximum of 20.

Information on each county's phase can be found at https://govstatus.egov.com/reopening-oregon#countyStatuses.

Primary Methods to Reduce Spread in Child Care and Early Education Programs

In response to understanding how COVID-19 spreads, the Oregon Health Authority has identified the most effective methods to reduce the spread within child care and early education programs. These methods include 1) the use of face coverings and face shields, 2) physical distancing, 3) restrictions on group size and creation of group stability, and 4) cleaning and sanitation practices.

Use of Face Coverings and Face Shields

The available evidence points to the importance of face coverings. Face coverings "provide significant protection" and are the "best for 'source control' to prevent someone who has COVID-19 from spreading to others."[16] Face coverings come in three forms: cloth face coverings, face shields, and medical grade face masks. Cloth face coverings have the advantage of creating a complete-or near-complete seal on sides of the face. Face shields have the advantage of being easy to disinfect, making lip reading possible for those who are deaf/hard of hearing, can be easily washed and re-used, and preventing users from touching their face. But a concern is that face shields are open on the sides, providing some possibility for aerosols and small particles to float in (Oregon Health Authority, July 2020). In addition, face coverings and face shields are not safe for children younger than two, and may not be practical for preschool-aged children or for some children with developmental delays and disabilities (Oregon Health Authority, July 2020). At this time, medical-grade face masks are reserved for situations when someone is in direct contact with someone who is symptomatic of COVID-19.

During the public comment period, the ELD received many statements regarding concerns about cloth face coverings, including discomfort, impacts on communication, limited durability, face touching to put on, take off, and adjust, and cost burdens for providers and families. For example, child care and

early education professionals raised issues such as face coverings contributing to setbacks for child's social, emotional, or language development, and difficulties with prolonged use for adults, especially those with health conditions. Some child care and early education providers stated that the required use of face shields or face coverings is a restriction on individual liberty, particularly when they are providing child care in a home setting.

These considerations were taken into account but were outweighed by the growing evidence that face shields or face coverings offer protection to children and adults from exposure. The guidelines require use of face shields or face coverings within the child care and early education settings with some exceptions. The approved use of face shields as a form of face covering helps to address potential concerns around setbacks for child's social, emotional, or language development, and concerns around adult health conditions.

Physical Distancing

Physical distancing is one of the most effective strategies for helping to reduce the spread of COVID-19.[17] Yet, within the child care and early education environment, it is not always feasible to maintain physical distancing as a primary strategy for helping to stop the spread of COVID-19. Physical distancing for young children is at odds with nurturing and responsive caregiving. This is also the

case for children of any age with certain disabilities and developmental delays. Therefore, the public health approaches for child care and early education programs relies more on limiting physical contact where possible and relies heavily on other measures, such as the use of face coverings, stable groups of adults and children, and frequent handwashing, cleaning, and sanitation (OHA, July 2020).

ELD outreach with providers raised some issues about procedures that limit physical contact. For example, Certified Family (CF) providers raised concerns about drop-off and pick-up occurring outside of the home, noting that these procedures could result in additional costs to implement, due to increased staffing. Other comments spoke to concerns about disallowing certain activities that can increase the likelihood of physical contact among children but are otherwise developmentally appropriate and enjoyed by young children in care.

While it is not possible to completely eliminate physical distancing in the child care and early education programs, the guidelines take steps to balance these concerns and limit close physical contact where possible. For example, toy sharing and food sharing practices typically associated with child care and early education are modified, and adults in the child care and early education setting are required to practice physical distancing when they are not caring for children, such as when they are on a break.

Group Size and Group Stability

Group size and group stability, for both children and adults, is an area of great focus for helping to reduce the spread of COVID-19 in child care and early education settings. These two methods limit the number of potential contacts that children or adults may have with someone who has COVID-19, helping to limit transmission. The science has suggested that smaller group sizes are better but currently the science has not been able to provide a specific number. The original recommendation from the CDC was group sizes of 10 or less, however the CDC removed that guidance.

Besides group size, the practice of group stability is another key element to help reduce the spread of COVID-19. Also known as cohorts, these stable groups of children and adults help manage risks by reducing exposure and facilitating contact tracing in the potential spread of COVID-19 (Oregon Health Authority, July 2020). In stable groups, a reduced number of children and adults are interacting. If someone becomes infected, fewer people are exposed and fewer may have to quarantine if there is a positive case. Having a stable group has implications for the engagement of other adults who are not part of the stable group: only those adults who are essential to assuring the health, safety and development of the children can interact with these stable groups (Oregon Health Authority, July 2020).

The initial guidance significantly reduced group size for preschool and school-aged children in Certified Center (CC) and Certified Family (CF) programs. During the comment period, providers stated that these restrictions caused a tremendous financial burden for providers and families alike. Most programs are dependent on tuition for revenue, so reduced group size results in a direct reduction in program income. Providers also noted that public financing for Emergency Child Care Facilities in Oregon has not been sufficient to act as replacement for

tuition revenue. Others noted that current enrollments are lower than usual even at smaller group sizes. The requirement for stable groups may also create a financial burden by not allowing programs to cluster children from more than one group at the beginning or end of the day. Child care and early education providers stated that they will go out of business if these requirements are maintained and there are not additional sources of public revenue.

Parents and caregivers also expressed concern that they cannot afford increased tuition payments. Parents and caregivers are already making substantial payments for child care and early education. They cannot afford to assume the increase in tuition that comes with these pared down group sizes for preschool and school-aged child care. It is beyond their means.

Other comments spoke to the potential for families to make choices about their care arrangements that are less safe. ELD received comments regarding the concern of families using illegal child care if there is less regulated supply. Other public health concerns were raised regarding less access for children to participate in the state's pre-K programs, such as Oregon Pre-Kindergarten and Preschool Promise, due to requirements that lessen their enrollments.

Based on all the information available, group size in the revised guidelines for counties in Phase 1 and 2 returns to the original in licensing, except for school-age. The guidelines also clarify that stable group requirements should not limit facility access for breastfeeding parents, as the burden on child development (parent-child attachment and feeding and nutrition, see CFOC 4.1, intro, page 161, Food and Nutrition Service) is high from prohibiting breastfeeding.[18]

Cleaning and Sanitation

Cleaning and sanitation practices are essential tools in helping to reduce the spread of COVID-19. COVID-19 can be spread in many ways. While person-to-person interaction is the main way COVID-19 is spreading, the virus can also spread via contaminated surfaces. When a healthy person touches a surface contaminated with COVID-19 and then touches their face, eyes, or mouth, they risk getting infected. COVID-19 requires a stepped-up approach that goes beyond the current licensing framework. According to the Oregon Health Authority, it is necessary to maintain strong focus on cleaning regimens (Oregon Health Authority, July 2020).

ELD received comments noting that the increased frequency of cleaning and building maintenance will incur additional costs to programs and to parents and will require extra staff time and effort to implement. For example, programs may incur additional costs for purchase of extra cleaning products. ELD also received many comments from parents and providers that recognized the importance of stepped-up cleaning and sanitation practices. Parents in particular valued these practices. There is also a potential burden on child development from the extra rounds of handwashing that are now required to help stem the transmission of COVID-19. However, some providers submitted comments explaining how they were already integrating learning into these additional practices with children.

The meaningful role that increased attention to cleaning and sanitation plays in reducing the spread of COVID-19 outweighed the additional burden to providers and families of requiring additional cleaning and sanitation practices in the revised guidelines. COVID-19 cleaning and sanitation practices are built on the base of cleaning and sanitation found in Oregon's licensing requirements. The guidelines provide some options to help reduce cost. For example, child care and early education programs—whether Certified Center (CC), Certified Family, or Registered Family—must make available hand hygiene stations upon entrance. The financial burden is reduced by the option of a sink with soap and water or the less costly option of hand sanitizer.

Equity

COVID-19 has exposed and exacerbated historical and structural inequities that have long characterized the child care and early education system. Before COVID-19, in Oregon, race, income, and zip code served as powerful predictors of whether a child participated in a quality child care and early education program prior to Kindergarten. The supply of child care and early education programs in communities of concentrated poverty, rural communities, and racially isolated communities was inadequate – many of these communities constituted a child care desert.[19]

In addition, the vast majority of child care and early education staff in Oregon are women, disproportionately women of color, immigrant women, and low-income women. Decades of studies have demonstrated the inadequate wages and lack of benefits, such as health insurance and paid leave, and less respect associated with the profession, despite a growing recognition of the critical importance of this period for healthy child development. Moreover, racial disparities in compensation in the field are evident. A 2019 study found that African American and Latinx child care workers are more likely to occupy lower-level positions within child care programs and—even accounting for education levels—are paid less than their white peers.

The state of emergency has revealed the fact that Oregon does not have a child care system that can easily withstand this pandemic. While the birth to five workforce has been deemed essential, the designation is in name only. The inequities noted above mean that many of these women lack adequate support to ensure their safety and protection during this emergency. This is especially true for the 20% of the Registered Family (RF) child care workforce in Oregon that is over the age of 60, and the more than one third are Black, Indigenous, and People of Color (BIPOC), who studies show are at greater risk of contracting and getting severely ill from COVID-19.

Child care closures due to COVID-19 are making it even more difficult for families to find and afford child care that is essential to their workforce participation and their children's healthy development, particularly for families that struggle to afford it, and for families with a young child with special needs. According to the University of Oregon's Rapid Assessment of Pandemic Impact on Development Early Childhood Household Survey Project (RAPID-EC),[20] families with young children are facing increased stress due to COVID-19, largely driven by concerns about meeting basic needs due to loss of income. RAPID-EC data has also showed a widening income gap between Black and Latinx households with young children compared to other households.

Responding to the inequitable impacts of this crisis on families and child care providers requires attention to the structural and historic inequities that predate the pandemic and not creating new inequities caused by COVID-19. Our current crisis makes finding equitable solutions both more challenging and more urgent. These guidelines seek to strike a balance among virus-prevention measures most important to slow the spread of COVID-19, especially in BIPOC communities that are hardest hit. One of the major goals of these guidelines is to keep children, providers, and families safe in the child care setting, and ensuring that child care and early education is available for low-income populations, rural communities, and communities of color that depend on it.

The realities of living through a dangerous global pandemic, mixed with the need for families –especially low-income and BIPOC families – to continue to leave home to go to work and for child care to stay afloat mean that there are no optimal or perfect choices.

Endnotes

1 https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/DISEASESAZ/Emerging%20Respitory%20Infections/Ready-Schools-Safe-Learners-Community-COVID-19-Metrics.pdf

2 https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/children/mis-c.html

3 Retrieved 7/26 from: https://www.nap.edu/catalog/25858/reopening-k-12-schools-during-the-covid-19-pandemic-prioritizing.

4 Retrieved 7/26 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/caring-for-newborns.html, Centers for Disease Control and Prevention, COVID-19, Evaluation and Management Considerations for Neonates At Risk for COVID-19.

5 Retrieved 8/2 at: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Children

6 Retrieved 8/2 from: https://doi.org/10.3201/eid2610.201315. Park YJ, Choe YJ, Park O, Park SY, Kim YM, Kim J, et al. Contact tracing during coronavirus disease outbreak, South Korea, 2020. Emerg Infect Dis. 2020 Oct

7 Retrieved 8/2 from: https://pediatrics.aappublications.org/content/146/2/e2020004879 COVID-19 Transmission and Children: The Child Is Not to Blame. Benjamin Lee and William V. Raszka Pediatrics August 2020, 146 (2) e2020004879; DOI: https://doi.org/10.1542/peds.2020-004879.

8 Retrieved 8/3 from: https://jamanetwork.com/journals/jamapediatrics/fullarticle/2768952?utm_source=undefined&utm_campaign=content-shareicons&utm_content=article_engagement&utm_medium=social&utm_term=073020#.XyNyImjnx-k.email Heald-Sargent T, Muller WJ, Zheng X, Rippe J, Patel AB, Kociolek LK. Age-Related Differences in Nasopharyngeal Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Levels in Patients With Mild to Moderate Coronavirus Disease 2019 (COVID-19). JAMA Pediatr. Published online July 30, 2020. doi:10.1001/jamapediatrics.2020.3651

9 Retrieved 8/2 from: https://public.tableau.com/profile/oregon.health.authority.covid.19#!/vizhome/OregonCOVID-19CaseDemographicsandDiseaseSeverityStatewide/DemographicData?:display_count=y&:toolbar=n&:origin=viz_share_link&:showShareOptions=-false

10 Retrieved 8/2 from: http://dx.doi.org/10.15585/mmwr.mm6928e1. Wortham JM, Lee JT, Althomsons S, et al. Char-acteristics of Persons Who Died with COVID-19 — United States, February 12–May 18, 2020. MMWR Morb Mortal Wkly Rep 2020;69:923-929.

11 https://covidtracking.com/race

12 https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

13 Retrieved 8/2 from: icon. Ellington S, Strid P, Tong VT, et al. Characteristics of Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–June 7, 2020. MMWR Morb Mortal Wkly Rep 2020; 69:769–775.

14 Retrieved 7/26 from: https://www.who.int/news-room/q-a-detail/q-a-how-is-covid-19-transmitted

15 https://govstatus.egov.com/or-covid-19

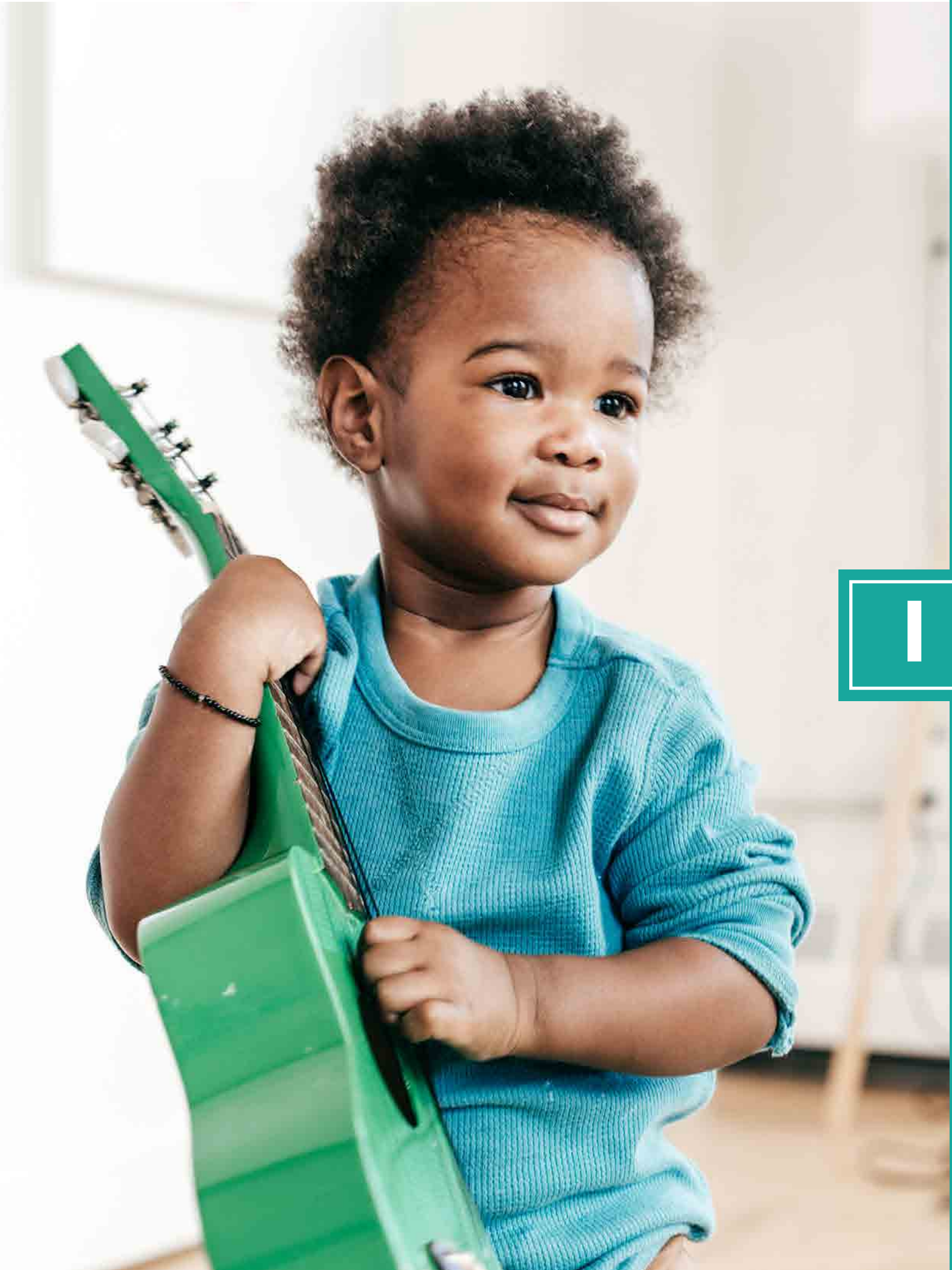
16 Retrieved 7/23 from: The Lancet, ARTICLES| VOLUME 395, ISSUE 10242, P1973-1987, JUNE 27, 2020, Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis, Derek K Chu, MD Prof Elie A Akl, MD, Stephanie Duda, MSc, Karla Solo, MSc, Sally Yaacoub, MPH, Prof Holger J Schünemann, MD et al. Published:June 01, 2020DOI: https://doi.org/10.1016/S0140-6736(20)31142-9. Aerosol Filtration Efficiency of Common Fabrics Used in Respiratory Cloth Masks, Abhiteja Konda, Abhinav Prakash, Gregory A. Moss, Michael Schmoldt, Gregory D. Grant, and Supratik Guha, ACS Nano 2020, 14, 5, 6339–6347, Publication Date: April 24, 2020, https://doi.org/10.1021/acsnano.0c03252. Hendrix MJ, Walde C, Findley K, Trotman R. Absence of Apparent Transmission of SARS-CoV-2 from Two Stylists After Exposure at a Hair Salon with a Universal Face Covering Policy — Springfield, Missouri, May 2020. MMWR Morb Mortal Wkly Rep 2020; 69:930-932. DOI: http://dx.doi.org/10.15585/mmwr.mm6928e2external icon. https://www.cdc.gov/mmwr/volumes/69/wr/mm6928e2.htm#suggestedcitation.

17 Retrieved 8/2 from: https://wwwnc.cdc.gov/eid/article/26/8/20-1093_article. Evaluating the Effectiveness of Social Distancing Interventions to Delay or Flatten the Epidemic Curve of Coronavirus Disease. Laura Matrajt and Tiffany Leung, Fred Hutchinson Cancer Research Center, Seattle, Washington, USA.

18 Retrieved 7/26 from: https://nrckids.org/CFOC, American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 4th ed. Itasca, IL: American Academy of Pediatrics; 2019. http://nrckids.org/files/CFOC4 pdf- FINAL.pdf.

19 Early Learning Division Analysis, August 2020.

20 Retrieved 8/3/2020 from: https://medium.com/rapid-ec-project/the-basic-truth-about-basic-needs-f505132d173c, https://medium.com/rapid-ec-project/a-hardship-chain-reaction-3c3f3577b30



Drop-Off and Pick-Up

Requirements

During COVID-19, a child care and early education program must:

1.1 Require parents or caregivers to drop-off or pick-up children from program staff outside of the facility.

> Registered Family (RF) or Certified Family (CF) providers only:
> When only one staff member is on site, parents or caregivers are allowed to enter but must wait for previous family to exit home before entering.

1.2 Require parents or caregivers to wear a face shield or face covering during drop-off or pick-up.

1.3 Require parents or caregivers during drop-off or pick-up to maintain physical distancing when not engaged in hand-off of children to staff.

1.4 Provide hand hygiene stations at the entrance of the facility–outside or immediately inside–so that children and staff can clean their hands as they enter.

> If a sink with soap and water is not available, provide hand sanitizer between 60%-95% alcohol at the entrance. Keep hand sanitizer out of children's reach and supervise use.

1.5 Sanitize or switch out writing utensils used for drop-off and pick-up between uses by different people.

Recommendations

The following practices are suggested to enhance health and safety:

A. Schedule staggered drop-off and pick-up times for families.

B. Encourage families to have the same person dropoff and pickup the child every day.

C. Talk with families about those at higher-risk of contracting COVID-19 not serving as the designated person for drop-off or pick-up. People with serious underlying medical conditions are more at risk for severe illness from COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html

D. Consider low or no contact sign-in and -out methods such as a different sheet, pen, or clipboard for each child, or have staff complete the sign-in and -out process.

2

Daily Health Check

Requirements

During COVID-19, a child care and early education program must:

2.1 Conduct a daily health check for any children, staff, and any other person (parent, maintenance, etc.) coming into the program. (See "Recordkeeping" section to document the health check.)

2.2 Require designated staff to take temperature of all entering children and other individuals coming into contact with a stable group. If they have a temperature of 100.4 Fahrenheit or over, they must be excluded. Staff may self-screen and attest to their temperature on a daily basis.

2.3 Ask all entering adults and children (or, if the child is not able to reliably answer, ask the adults who are dropping off the child):

1. Has the adult or child been exposed to a person with a positive case of COVID-19 in the past 14 days?

2. Has the adult or child been exposed to a person with a presumptive case of COVID-19 in the past 14 days?

- A "presumptive" case means the person was exposed to someone with COVID-19 and the presumptive adult or child showed symptoms in the past 10 days.

If they answered yes to either question 1 or 2, the child or adult must quarantine for 14 days. The 14-day quarantine starts on the day that child or adult last had contact with the COVID-19 case.

- The 14-day quarantine cannot be shortened by getting a negative COVID-19 test, or by getting a note from a medical professional.

3. Is the adult or child experiencing unusual cough, shortness of breath, or fever? "Unusual cough" means something not normal for this person (e.g., allergies, asthma).

If yes to question 3, that person must be excluded from the program for 10 days, and 24 hours symptom-free.

- With regard to cough and shortness of breath only, if the person has been checked by a medical professional and is cleared, they can remain in or return to the program following the documented direction of the medical professional. Anyone with a fever of 100.4 Fahrenheit is excluded. See additional information on exclusion and return to care under direction of a medical professional in the section "Responding to Possible and Confirmed Cases of COVID-19."

Daily Health Check

4. Does the child or adult have symptoms of diarrhea, vomiting, headache, sore throat, or rash?

If yes to question 4, that person must be excluded as follows.

- If seen by a medical professional and is cleared, they can remain in or return to the program following the documented direction of the medical professional.
- If not seen by a medical professional, they may return 24 hours after resolution of symptoms.

2.4 Staff members may self-screen and attest to their own health on a daily basis.

2.5 Document that a daily health check was completed on every person entering and write down pass or fail only. Do not record symptoms or temperature in order to maintain privacy.

2.6 Refer to OCC Exclusion Chart, found below, while completing daily health checks.

2.7 Wear appropriate face coverings and Personal Protective Equipment, as indicated in the Personal Protective Equipment for Children and Adults section of this document.

EXCLUSION SUMMARY

for Child Care and Early Education Operations During COVID-19

AUGUST 14, 2020

If child or staff member has had illness with fever, unusual cough, or shortness of breath in the last 10 days:

Person must be sent home and stay away from the facility for 10 days after onset of symptoms and 24 hours after both "fever free" and cough resolves.

- If person tests negative for COVID-19, they may return 24 hours after resolution of cough and "fever free."
- If a medical professional advised person they can return to care (e.g., diagnosed with something else and given antibiotics), they may return to care following the documented advice of the medical professional.

If child or staff member has symptoms of diarrhea, vomiting, headache, sore throat, or rash:

Person must be excluded; advise to consult a medical professional.

- If a medical professional advises person they can return to child care, they may return following the documented advice of the medical professional.
- If not seen by a medical professional, may return 24 hours after symptoms resolve.

If a child or staff member has been exposed to someone with a current presumptive or positive COVID-19 case:

Exposed person must quarantine for 14 days. Start counting 14 days from the last time they had contact with the person with the presumptive or positive COVID-19 case.

- ***For presumptive cases only,*** if the exposure was to a presumptive case of COVID-19, exclusion is required only if the child or staff member was "exposed" in the 10 days after the COVID-19 presumptive person started having symptoms. This is the period they would be infectious.

If a child or staff member develops these symptoms while at the facility or learns they have been exposed to a positive case while at the facility:

Separate the child or staff member until they can leave the facility and send home as soon as possible.

If a child or staff member has a household member with symptoms of COVID-19 that is not confirmed or presumptive:

Carefully monitor the child or staff member for symptoms. Encourage the ill household member to get tested.

Important Definitions

"Unusual cough" means out of the ordinary for this person – e.g., not usual asthma, allergies, common cold.

"Fever" means 100.4 degrees Fahrenheit or more.

"Fever free" means a temperature less than 100.4° Fahrenheit without the use of fever reducing medication.

"Exposure" means close contact (less than six feet) for longer than 15 minutes with a COVID-19 case.

"Presumptive case" means a person who was exposed to a positive COVID-19 case and has developed symptoms.

"Quarantine" means you stay away from other people when you may become sick, even if you have no symptoms.

Children cannot be denied care because of the fear of transmission of COVID-19:

In addition to Oregon laws prohibiting discrimination, a provider cannot refuse to enroll a child in the program based on a belief that the child is more susceptible to contracting COVID-19 due to the child's or parent's occupation, race, ethnicity, geographic location, disability, or pre-existing health condition.

For more information, visit oregonearlylearning.com/COVID-19-Resources.
Providers can also submit questions by emailing ProviderContact@state.or.us.

3

Recordkeeping

Requirements

During COVID-19, a child care and early education program must:

3.1 Keep daily logs separated by or indicating each stable group (people in that group or people who came in contact with that group). In addition to the reasons for recordkeeping under child care rules, additional requirements support potential contact tracing.

Registered Family (RF) and Certified Family (CF) providers only: all visitors during program hours must be recorded and a log of residents kept. Residents of the home over the age of 12 do not need to be included in the daily child care attendance records – they are assumed to be present.

3.2 Indicate in each daily log:

Child name.

Adult name(s) completing drop-off and pick-up (no signature is required).

Arrival and departure date and times.

Name of any staff or person coming in contact with a stable group, arrival and departure date and times.

Document daily health checks on all children, staff, and any person coming into the program (see Daily Health Check requirements for detailed guidance). Record only that the check was a pass or fail – not specific information.

If transportation is provided by the program, document names of all other riders, and their contact information (if not recorded elsewhere).

3.3 Daily logs must be retained for 2 years for all children (the usual amount of time per child care rules).

3.4 If a program is part of a K-12 school, this information can be recorded and incorporated into the school's records for contact tracing.

Recommendations

The following practices are suggested to enhance health and safety:

A. To minimize potential spread of disease from sharing writing utensils, staff should complete all required documentation, rather than parents or caregivers.

4

Family Engagement

Requirements

During COVID-19, a child care and early education program must:

4.1 Inform families of the requirements for operating during COVID-19, how programs are operating differently during this time, and any other program policies that are specific to COVID-19.

4.2 Communicate requirements that families must follow, including drop-off and pick-up procedures.

4.3 Provide information related to the facility and COVID-19 to families in a manner that they can understand.

4.4 When engaging families in formal activities that are normally conducted in-person such as parent-teacher conferences, council meetings, or other typically in-person activities, conduct virtually or via telephone.

4.5 Conduct any visits to the home for services or other programmatic reasons virtually.

4.6 If families cannot engage in virtual or telephonic visits, or for parents who enter the program to breastfeed, programs must create and follow a protocol for in-person family engagement that, at minimum, requires:

- Following physical distancing requirements with staff and children not in their household.
- Use of face shields or face coverings.
- Use of outdoor space if appropriate and available.
- Engage with only one family unit and any other necessary individuals, such as translators, at a time.
- Pre-scheduling (when possible).

4.7 Allow family members to enter the facility if there is a concern for the health and safety of their child. Family members entering the facility must follow requirements for adults in the facility.

4.8 Ensure breastfeeding parents, or parents or caregivers whose children have special feeding needs and who choose to come to the program to feed their child, are provided an appropriate space where other children are not present. The space must be cleaned and sanitized between visits.

4.9 Permit families seeking enrollment to visit the facility only when children are not present. Only one family may visit the facility at a time and the family must comply with daily health check and recordkeeping requirements, wear a face shield or face covering, and maintain physical distancing.

Family Engagement

Recommendations

The following practices are suggested to enhance health and safety:

A. Provide ways for families to understand their child's daily experience, such as family engagement and photo or video sharing applications, or daily reports via email or text message.

B. Limit the number of items that go from the facility into the home and from the home to the facility, especially those items that are not easily washed or sanitized.

C. Provide families with information about the spread of COVID-19 and support in understanding the latest public health guidance, including how their actions outside of the program may impact their child, other children, and staff, such as maintaining social distancing or wearing face coverings when outside of the family's home.

5

Group Size and Stable Groups

Requirements

During COVID-19, a child care and early education program must:

5.1 Assign and keep children in stable groups with the same assigned adults.

A new child may be added or moved to a different stable group if it is a permanent change.

5.2 Require staff to practice physical distancing (i.e., six feet) at all times within the facility with adults, as well as other staff who are not usually with the same stable group.

5.3 Require staff assigned to a stable group to practice physical distancing with children from other stable groups and take precautions to ensure children do the same.

Staff and children are not required to physically distance from adults or children within their stable group.

5.4 Only staff assigned to a stable group may be inside of classrooms with the following exceptions:

Additional adults outside of the stable group may be allowed into the classroom in order to provide:

- Specialized services to children such as those associated with Early Intervention or Early Childhood Special Education.
- Meet monitoring requirements of publicly funded or regulated programming.
- Maintain ratios during staff breaks (e.g., floaters).
- Service to the facility that cannot take place outside of program hours.

5.5 When providing outdoor activities, there cannot be more than one stable group of children in one outside area at a time. Programs may have separate areas as long as stable groups are kept apart and there is at least 75 square feet per child in that area.

5.6 Recorded Programs may use a visual barrier to define the space used outside.

5.7 No facility may serve more than 250 children.

5.8 Staff-to-child ratios and maximum group sizes must adhere to those specified in licensing rules by provider type, and by the provider's license which may be for fewer children. These group sizes and ratios, as well as any additional requirements, are below.

Group Size and Stable Groups

Requirements, Counties in Phase 1 and Phase 2

During COVID-19, a child care and early education program must:

5.9 **Preschool and School-Age Recorded Programs that operate in a home** must maintain a staff-to-child ratio of 1:10 and a maximum group size of 16.

5.10 **Registered Family (RF) provider** – may have up to one stable group of 10 children. Note: RF providers do not have square footage requirements related to the number of children in care.

Twelve children can be enrolled in a stable group but only 10 (or fewer, in the case of infants and in some family child care homes) can be in a classroom in attendance or on site at the same time.

Of the 10 total children, there may be no more than six children ages preschool and younger (including the provider's children), of which only two children may be under 24 months of age.

5.11 **Certified Family (CF) provider** – may have no more than 16 children with 20 children as the maximum size for a stable group.

20 children can be enrolled in a stable group but only 16 (or fewer, in the case of infants and in some family child care homes) can be in attendance at the same time.

Optionally, a CF provider may split children into two stable groups in different classrooms. No more than 10 children in attendance per class room at the same time (still no more than 16 total children on site in the CF at the same time). Each separated, stable group may have 12 children enrolled.

- There must be a physical barrier between the two groups, at least four feet high and strong enough to prevent kids from going over or through it.
- The room barrier must be approved by a licensing specialist.

Each group of children must be in a space that meets the minimum of 35 square feet per child. If a program cares for more than 12 children in a group, the remaining four children must meet a 50 square feet per child requirement.

Group Size and Stable Groups

5.12 **Certified Center (CC), Recorded Programs, and Schools** – must meet the ratios in Table 1 below, unless licensed to operate under Table 2.

Each group of children must be in a space that meets the minimum of 35 square feet per child.

Table 1: Child Care Regulations, Ratio, and Group Size

Age of Children	Minimum Number of Caregivers to Children	Maximum Number of Children in a Group
Six Weeks of Age through 23 Months	1:4	8
24 Months of Age through 35 Months	1:5	10
36 Months of Age to Attending Kindergarten	1:10	20
Attending Kindergarten and Older	1:15	Phase 1 and Phase 2: 20

Table 2: Child Care Regulations, Ratio, and Group Size

Age of Children	Minimum Number of Caregivers to Children	Maximum Number of Children in a Group
Six Weeks of Age and Under 30 Months	1:4	8
30 Months of Age to Attending Kindergarten	1:10	20
Attending Kindergarten and Older	1:15	Phase 1 and Phase 2: 20

A Center may have up to four additional children enrolled in the stable group, provided the children in attendance at the same time in a classroom do not exceed the maximum group number in the charts above.

Gyms, cafeterias, and other similar very large spaces are limited to one group of 20 (or split into two groups of 10). Those very large rooms cannot be split into multiple “classrooms” for multiple groups of 20.

Group Size and Stable Groups

Recommendations, Counties in Phase 1 and Phase 2

The following practices are suggested to enhance health and safety:

A. A group may have more staff/teachers than the minimum required by licensing or less children than the maximum allowed in order to provide higher quality care.

B. Programs who have staff or serve children at increased risk for COVID-19 infection should consider serving less than the maximum number of children per group.

Requirements, Counties in Baseline

During COVID-19, a child care and early education program must:

5.13 **Preschool and School-Age Recorded Programs that operate in a home** must maintain a staff-to-child ratio of 1:10 and a maximum group size of 10.

5.14 **Registered Family (RF) provider** – may have up to one stable group of 10 children. Note: RF providers do not have square footage requirements related to the number of children in care.

Twelve children can be enrolled in a stable group but only 10 (or less, in the case of infants and in some family child care homes) can be in a classroom in attendance or on site at the same time.

Of the 10 total children, there may be no more than six children ages preschool and younger (including the provider's children), of which only two children may be under 24 months of age.

5.15 **Certified Family (CF) provider** – may have no more than 16 children total in two stable groups.

No more than 10 children in attendance per group at the same time (still no more than 16 total children on site in the CF at the same time).

Each group of children must be in a space that meets the minimum of 35 square feet per child.

There must be a physical barrier between the two groups, at least four feet high and strong enough to prevent kids from going over or through it.

The room barrier must be approved by a licensing specialist.

Group Size and Stable Groups

5.16 **Certified Center (CC), Recorded Programs, and Schools** – must meet the ratios in Table 3 below, unless licensed to operate under Table 4.

Each group of children must be in a space that meets the minimum of 35 square feet per child.

Table 3: Child Care Regulations, Ratio, and Group Size

Age of Children	Minimum Number of Caregivers to Children	Maximum Number of Children in a Group
Six Weeks of Age through 23 Months	1:4	8
24 Months of Age through 35 Months	1:5	10
36 Months of Age to Attending Kindergarten	1:10	10
Attending Kindergarten and Older	1:15	10

Table 4: Child Care Regulations, Ratio, and Group Size

Age of Children	Minimum Number of Caregivers to Children	Maximum Number of Children in a Group
Six Weeks of Age and Under 30 Months	1:4	8
30 Months of Age to Attending Kindergarten	1:10	10
Attending Kindergarten and Older	1:15	10

A Center may have up to four additional children enrolled in the stable group, provided the children in attendance at the same time in a classroom do not exceed the maximum group number in the charts above.

Gyms, cafeterias, and other similar very large spaces are limited to two groups. This applies to school-age only.

6

Personal Protective Equipment for Children and Adults

Requirements

During COVID-19, a child care and early education program must:

6.1 Require all staff, contractors, other service providers, or visitors or volunteers who are in the facility or in the designated child care section of the child care provider's home, to wear a face shield or face covering. Face coverings and face shields must follow CDC guidelines Face Coverings: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html.

Providers and staff only: exception to requirement to wear a face shield or face covering if they have a medical condition or disability, as documented by their doctor's order, that prevents them from wearing a face covering.

6.2 Require all children who are in grades Kindergarten and up who are in the child care facility or the designated child care section of Registered Family (RF) or Certified Family (CF) program to wear a face shield or face covering. Face coverings or face shields must follow CDC guidelines for face coverings: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html.

6.3 Adults and children who are kindergarten age and up must wear a face shield or face covering when outside if six feet of physical distance cannot be maintained.

6.4 Allow a child between two years and Kindergarten to wear a face covering or face shield, if: requested by the parent/guardian, the face covering or face shield fits the child's face measurements, and the child is able to remove the face covering or face shield themselves without assistance.

6.5 If a child removes a face covering or face shield, or demonstrates a need to remove the face covering or face shield for a short-period of time, staff:

Must supervise the child to maintain six feet or more of physical distancing from all adults and children while the face shield or face covering is removed.

If needed, show the child how to effectively wear a face shield or face covering.

Guide the child to re-engage in safely wearing a face shield or face covering.

Children cannot be disciplined for the inability to safely wear a face shield or face covering.

Personal Protective Equipment for Children and Adults

6.6 Allow children in grades Kindergarten and up to **not** wear a face shield or face covering:

- If they have a medical condition that makes it difficult for them to breathe with a face covering, as documented by their doctor's order.
- If they experience a disability that prevents them from wearing a face covering, as documented by their doctor's order.
- If they are unable to remove the face shield or face covering independently.
- While sleeping.

6.7 Ensure children under two **never** wear a face shield or face covering.

6.8 Require staff or child to wash hands before putting on a face shield or face covering, after taking face shields and face coverings off, and anytime the face shield or face covering is touched.

- Hand-sanitizing products with 60-95% alcohol content may be used as an alternative to washing hands.
- Children must be supervised when using hand sanitizer, and it must be stored out of reach of children when not in use.

6.9 Require face coverings to be washed daily or a new face covering to be worn daily.

- After removal of a soiled face covering, the face covering should be put away into a secure place that is not accessible to others. For example, it could be placed into a plastic bag or plastic container that is inaccessible to children prior to being cleaned.

6.10 A face shield must be wiped down with disinfectant at the end of the day after use.

6.11 Require disposable face coverings or face shields to be worn only once.

6.12 Face coverings must be changed after a daily health check if the adult interacted with a sick child.

6.13 Face shields must be sanitized after the daily health check if the adult interacted with a sick child. For Certified Centers and Recorded Programs, face shields must be sanitized after the daily health checks are completed.

6.14 For Certified Centers and Recorded Programs Only: Require adults who engage in health and safety checks to wear a clean, outer layer of clothing (e.g., a larger size, long sleeve button down shirt, a smock, or an apron) during the daily health checks. Require adults, such as floaters or early interventionists, interacting with multiple, stable groups to wear a clean, outer layer of clothing when moving to a new group.

Personal Protective Equipment for Children and Adults

6.15 Require a clean outer layer of clothing (e.g., a larger size, long sleeve button down shirt or a long-sleeved smock, or a sheet, blanket, etc.) to be worn by adults when feeding infants, and for hair to be tied back if necessary.

6.16 Ensure any child care staff providing direct contact care and monitoring of children or other staff displaying COVID-19 symptoms, prior to their exclusion from the child care setting, to maintain six feet of physical distancing and to wear a face shield or face covering.

6.17 Require clothing to be changed after being soiled by bodily fluids.

Recommendations

The following practices are suggested to enhance health and safety:

A. Develop written agreements with parents to document their requested use of face shields or face coverings for their child(ren) age two to Kindergarten.

B. Any staff providing direct contact care and monitoring of children or other staff displaying COVID-19 symptoms, prior to their exclusion from the child care setting, are recommended to wear a “face mask.” A “face mask” is medical-grade equipment, including surgical masks and N-95 respirators. A face covering or face shield must be worn if a mask is unavailable. Physical distancing must occur whether a face mask, face covering, or face shield is worn.

C. Plexiglas or clear plastic barriers may be used for additional protection at an entry area, such as a front desk or child check-in area. This barrier must be at least three feet wide and four feet tall, centered at the level of the mouth and nose level.

7

Daily Activities

Requirements

During COVID-19, a child care and early education program must:

7.1 No field trips are permitted unless they are conducted fully outdoors. Field trips to indoor venues are not permitted.

No transportation is permitted for field trips unless there is no outdoor space available at the program or no outdoor space available within walking distance.

When going on outdoor field trips:

- Adults and children must wash their hands or use hand sanitizer before and after.
- Programs shall keep stable groups separated from each other and away from other children as much as possible.

7.2 Maintain at least 36 inches between mats, beds, or cots and sleep head-to-toe (children are arranged so that the head of a person in one bed is at the other end as the head of the person in the next bed) during naptime and overnight care.

7.3 Limit sharing materials and toys between children during an activity. If sharing occurs, children must wash their hands with soap and water or use hand sanitizer at the end of the activity and prior to starting a new activity.

7.4 Clean and sanitize classroom materials between uses.

7.5 Discontinue the use of classroom areas or materials where children must interact with common materials while engaging, such as shared sand and water tables, or outdoor sandboxes.

Recommendations

The following practices are suggested to enhance health and safety:

A. Reduce time spent in whole or large group activities.

B. Limit the number of children in each program space, such as learning centers.

C. Depending on the size of the group and the age of the children, separate learning environments into individual spaces for each child.

D. Minimize time standing in lines and take steps to ensure that distance between the children is maintained.

Daily Activities

E. Incorporate additional daily outside time, with no more than one stable group of children in one outside area at a time. You may have separate areas as long as stable groups are kept apart and there is at least 75 square feet per child in that area.

F. Sanitize outdoor play equipment between groups of children.

G. Increase the distance between children during table work.

H. Plan activities that do not require close physical contact between multiple children.

I. Provide children with their own materials and equipment if possible (e.g., writing utensils, scissors, high chairs).

J. Incorporate assigned mats at circle time.

K. For sensory activities, staff can arrange the room for individually planned sensory activities that utilize totes or trays so each child can have their own.

8

Handwashing and General Hygiene

Requirements

During COVID-19, a child care and early education program must:

8.1 Require staff and children to wash hands for at least 20 seconds (hand sanitizer with alcohol content between 60-95% is allowed when an asterisk* appears):

- Before and after eating, preparing food, and or bottle preparation.
- Before and after administering medication.
- After toileting or assisting with toileting.
- Before and after diapering.
- After wiping a nose, coughing, or sneezing.*
- After coming in from outside.*
- Upon entering and leaving the child care facility.*
- If staff are moving between stable groups. *
- After sharing toys, learning materials, etc.*

8.2 Make handwashing materials easily accessible to each stable group.

8.3 Hand sanitizer must be stored out of reach of children when not in use.

9

Food and Nutrition

Requirements

During COVID-19, a child care and early education program must:

9.1 Eliminate children serving themselves from communal platters in the manner of family-style meals. Have one staff member serve everyone from communal dishes.

9.2 Staff must wash their hands before and after assisting children with eating.

9.3 Closely supervise all meal times, including infant feeding and toddler meals, to prevent children from sharing and/or touching each other's food.

9.4 Allow breastfeeding parents or those whose children have special feeding needs to enter the program for the purposes of feeding.

9.5 Discontinue use of drinking fountains except for filling other containers such as water bottles.

Recommendations

The following practices are suggested to enhance health and safety:

A. Programs may provide bagged and individualized lunches, accept lunches and snacks from families, or provide meals prepared on site.

B. Arrange or stagger meal schedules so that a smaller group of children is eating at one time.

C. If space allows, consider providing six feet of physical distancing between children during meals.

10

Cleaning and Building Maintenance

Requirements

During COVID-19, a child care and early education program must:

10.1 Operate ventilation systems properly and/or increase circulation of outdoor air as much as possible by opening windows and doors, using fans, and other methods.

10.2 Surfaces in General

Wear disposable gloves when cleaning and disinfecting surfaces. Instead of disposables, you can wear reusable (e.g., rubber) gloves except when cleaning and disinfecting areas around a sick person or when in contact with diapers, stool, blood and other bodily fluids.

Wash hands with soap and water as soon as you remove the gloves.

Keep all disinfectants locked up. Keep hand sanitizers out of the reach of children.

Clean dirty surfaces using a detergent or soap and water prior to disinfection.

Use products approved by the EPA for use against SARS-CoV-2 for household disinfectant: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19. Follow instructions on the label (e.g., concentration, application method, contact time).

Diluted household bleach solutions are also allowable when appropriate for the surface.

- Mix water (not hot water) with bleach using instructions on the bleach bottle. Leave diluted bleach mixture on the surface for at least one minute.
- Do not mix bleach or other cleaning and disinfection products together. This can cause fumes that may be very dangerous to breathe.
- If using bleach, make a fresh bleach dilution daily; label the bottle with contents and the date mixed.

10.3 Child Care Areas – Table 5 provides a summary of the required cleaning schedule and method of cleaning. Review the requirements below for important details.

Toys

- Collect “mouthed” toys after each use by a child.
- Collect all other toys daily or as they become dirty.

Cleaning and Building Maintenance

- Sort toys into separate containers: one for cloth and stuffed toys and one for wood and plastic toys. Sorting the toys ahead of time will make it easier to wash and sanitize them.
- At the end of the day, or at a specified time (i.e., naptime), clean, rinse, and sanitize toys.
- Toys may be cleaned in a washing machine, dishwasher, or by hand.
- If washing toys in a washing machine:
    - Use hot water and detergent.
    - Dry toys completely in a hot dryer when possible.
    - Many soft toys made of fabric, such as stuffed animals, rattles, and dress-up clothes may be washed in a washing machine. Check instructions on toy.
- If washing toys in a dishwasher:
    - Use the proper amount of dishwasher detergent recommended by manufacturer.
    - Run toys through the complete wash and dry cycle.
    - Do not wash toys with dirty dishes, utensils, etc.
    - Some hard toys such as wood, plastic or metal may be washed in a dishwasher. Check instructions on toy.
- If washing toys by hand, use the following process:
    - Step 1: Wash and scrub toys thoroughly with soap or detergent and warm water to remove most of the dirt, grime, and saliva. It is important to clean toys before sanitizing them because the sanitizer kills germs better on clean surfaces.
    - Step 2: Rinse toys with water to remove the dirt, soap residue, and germs to help make a clean surface.
    - Step 3: Sanitize toys. Sanitizing reduces the germs from surfaces to levels that are considered safe.
- Dip the toys in a sanitizing solution, or cover the toys sufficiently with spray. Protect your skin by wearing household rubber gloves.
- Allow toys to dry completely (i.e. overnight) or allow a 2-minute contact time before wiping toys dry with a paper towel.

Cleaning and Building Maintenance

- When using a bleach solution for sanitizing, chlorine from the sanitizing bleach solution evaporates off the toys so no residue remains, and further rinsing is not necessary.

Objects Intended for the Mouth

- Thermometers, pacifiers, teething toys, and similar objects must be cleaned and reusable parts sanitized between uses.
- Pacifiers may not be shared.

Soft Surfaces

- For soft (porous) surfaces, such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean and disinfect with appropriate cleaners indicated for use on these surfaces.
- Vacuum carpeted floor and rugs daily when children are not present.
- After cleaning:
    - If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely
- Otherwise, use products that have been approved by the EPA for use against SARS-CoV-2 that are suitable for porous surfaces: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19.

High Touch Surfaces

- High touch surfaces, such as doorknobs, light switches, non-food countertops, handles, desks, phones, keyboards, and toilets, must be disinfected daily, including at the end of the day.

Specific Additional Requirements for Registered Family (RF) and Certified Family (CF) Providers

- Spaces must be cleaned between the times when household members utilize the space and the times when a group of children utilize the designated child care space.
- Items used for child care must be washed separately from items used by family or household members.

Cleaning and Building Maintenance

Sleeping Areas –Table 5 provides a summary of the required cleaning schedule and method of cleaning. Review the requirements below for important details.

- Handling and washing linens, clothing, and other items that go in the laundry.
    - Wash hands with soap and water frequently when bagging, cleaning, and disinfecting linens, clothing and other items that go in the laundry.
    - Wear disposable gloves when handling dirty laundry from a person who is sick.
    - Bag or contain all soiled linens, clothing, and other items that go in the laundry before removing from the area.
    - Do not shake dirty laundry.
    - Launder items according to the manufacturer's instructions. Use the warmest appropriate water setting and dry items completely.
    - Dirty laundry from an ill person can be washed with other people's items.

Bed sheets, pillow cases, cribs, cots, mats, and blankets

- Clean and sanitize bed sheets, pillow cases, cribs, cots, mats and blankets before use by another child.

Toileting and Diaper Areas – Table 5 provides a summary of the required cleaning schedule and method of cleaning. Review the requirements below for important details.

- Disinfect handwashing sinks, counters, toilets, toilet handles, floors, changing tables, potty chairs, diaper trash cans, and bathroom floors at the frequency in Table 5.

Food Areas – Table 5 provides a summary of the required cleaning schedule and method of cleaning. Review the requirements below for important details.

- Sanitize food area items including refrigerator, freezer, eating utensils, bottles, dishes, kitchen counters, food preparation surfaces, food preparation sinks, kitchen equipment (blenders, can openers, pots and pans, cutting boards), tables and highchair trays, highchairs, and kitchen floors at the frequency in Table 5.

Cleaning and Building Maintenance

Electronics – Table 5 provides a summary of the required cleaning schedule and method of cleaning. Review the requirements below for important details.

- Follow manufacturer's instructions for cleaning and disinfecting.
- If no guidance, use alcohol-based wipes or sprays containing at least 70% alcohol. Dry surfaces thoroughly.

10.4 Table 5. Required Cleaning Schedule (see requirements above for details)

Note: At times, it may be necessary to clean, rinse, sanitize and/or disinfect more frequently. The 3-Step Method is 1. WASH 2. RINSE and 3. SANITIZE or DISINFECT

Sanitizing solution is used to reduce germs from surfaces but not totally get rid of them. Sanitizers reduce the germs from surfaces to levels that are considered safe. The sanitizing 3-Step Method is most often used for food surfaces, kitchens, and classrooms.

Disinfecting solution is used to destroy or inactivate germs and prevent them from growing. Disinfectants are regulated by the U.S. Environmental Protection Agency (EPA). The disinfecting 3-Step Method is most often used for body fluids and bathrooms/diapering areas.

Table 5: Required Cleaning Schedule

Item	Sanitize or Disinfect?		Frequency *Note: At times, it may be necessary to clean, rinse, sanitize, and/or disinfect more frequently*			Notes
	Sanitize	Disinfect	Daily	Weekly	Before/After Each Use	
Child Care Areas						
Toys	X		X		X	• Collect "mouthed" toys after each use by a child. • Collect all other toys daily or as they become dirty.
Objects intended for the mouth	X				X	• Thermometers, pacifiers, teething toys, and similar objects must be cleaned and reusable parts sanitized between uses. • Pacifiers may not be shared.

Cleaning and Building Maintenance

Table 5: Required Cleaning Schedule, Continued						
Item	**Sanitize or Disinfect?**		**Frequency** *Note: At times, it may be necessary to clean, rinse, sanitize, and/or disinfect more frequently*			**Notes**
	Sanitize	**Disinfect**	**Daily**	**Weekly**	**Before/After Each Use**	
Child Care Areas, Continued						
Soft surfaces (e.g., carpeted floor, rugs, and drapes)		**X**	**X**			• Vacuum carpeted floor and rugs daily. • Disinfect if soft surfaces are contaminated, using products approved by EPA for use against SARS-CoV-2.
High touch surfaces (e.g., doorknobs, light switches, non-food countertops, handles, desks, phones, keyboards, and toilets)		**X**	**X**			• Disinfect at the end of each day.
Specific additional requirements for Registered Family (RF) and Certified Family (CF) Providers • Spaces must be cleaned between the times when household members utilize the space and the times when a group of children utilize the designated child care space. • Items used for child care must be washed separately from items used by family or household members.						
Sleeping Areas						
Linens, clothing, and other items that go in the laundry				**X**		• Clean at least weekly and in between use by another child.
Bed sheets, pillow cases, cribs, cots, mats, and blankets	**X**			**X**		• Clean and sanitize bed sheets, pillow cases, cribs, cots, mats, and blankets before use by another child and at least weekly.

Cleaning and Building Maintenance

Table 5: Required Cleaning Schedule, Continued						
Item	**Sanitize or Disinfect?**		**Frequency** *Note: At times, it may be necessary to clean, rinse, sanitize, and/or disinfect more frequently*			**Notes**
	Sanitize	**Disinfect**	**Daily**	**Weekly**	**Before/After Each Use**	
Toilet and Diapering Areas						
Handwashing sinks and faucets		X			After each use	
Changing tables		X			After each use	
Potty chairs		X			After each use	
Diaper trash cans		X	X			
Bathroom floors		X	X			• At the end of the day.
Countertops			X			• At the end of the day.
Toilets			X			
Food Areas						
Food preparation surfaces	X				X	
Eating utensils and dishes	X				After each use	
Tables and high chair trays	X				X	
Countertops	X		**at end of day**		After each use clean	
Food Preparation Appliances	X		X		After each use	
Mixed use tables	X					• Before serving food.
Refrigerator	X					• Clean monthly.
Food preparation sinks	X		X			

Cleaning and Building Maintenance

Table 5: Required Cleaning Schedule, Continued						
Item	**Sanitize or Disinfect?**		**Frequency** *Note: At times, it may be necessary to clean, rinse, sanitize, and/or disinfect more frequently*			**Notes**
	Sanitize	**Disinfect**	**Daily**	**Weekly**	**Before/After Each Use**	
Food Areas, Continued						
Kitchen floors	X		X			
Electronics						
Electronics		X				• Follow manufacturer's instructions.

Recommendations

The following practices are suggested to enhance health and safety:

A. Consider running ventilation systems continuously and changing the filters more frequently. Do not use fans if they pose a safety or health risk, such as increasing exposure to pollen/allergies or exacerbating asthma symptoms. For example, do not use fans if doors and windows are closed and the fans are recirculating the classroom air.

B. Consider putting a cleanable cover on electronics, such as tablets, touch screens, keyboards, and remote controls.

C. For children or adults with asthma, use bleach products sparingly and, when possible, when children are not in the facility or room. If possible, use wipes or apply product directly to a dampened towel, rather than using spray when there are children or adults with asthma.

Responding to Possible and Confirmed Cases of COVID-19

Requirements

During COVID-19, a child care and early education program must:

11.1 Make a plan for a confirmed case and the possibility that the facility may need to close. (See "COVID-19 Health and Safety Plan" section).

11.2 Decisions about required closure will be made in conjunction with Early Learning Division staff and the local public health authority.

11.3 Have a plan for a child with particular health needs.

If an enrolled child has particular health needs or susceptibility to disease, including COVID-19, the provider and parent must develop a care plan for the child. The provider must ensure all staff engaged with the child understand the plan.

11.4 In addition to Oregon laws prohibiting discrimination, a provider cannot refuse to enroll a child in the program based on a belief that the child is more susceptible to contracting COVID-19 due to the child's or parent's occupation, race, ethnicity, geographic location, disability, or pre-existing health condition.

11.5 A provider must exclude staff and children for COVID-19 symptoms or cases as follows:

The adult or child has had an illness with fever, unusual cough, or shortness of breath in the last 10 days.

- Unusual cough means out of the ordinary for this person – e.g., not usual asthma, allergies, common cold.
- Fever means 100.4 degrees Fahrenheit or more, without the use of fever reducing medication.
- The individual must stay away from child care for 10 days after onset of symptoms and 24 hours after both fever and cough resolve, without the use of a fever reducing medication.
    - The 10-day rule for exclusion applies if the persons tests positive, or does not get tested.
    - If a child or staff member with symptoms of COVID-19 tests negative, they may return 24 hours after resolution of cough and fever without the use of fever-reducing medication.
    - If a child or staff member with symptoms of COVID-19 is advised by a medical professional they can return to care (e.g., diagnosed with something else and given antibiotics), they are allowed return to care. Documentation from the medical

Responding to Possible and Confirmed Cases of COVID-19

professional is required. The person must be fever-free for at least 24 hours.

The adult or child has been exposed to someone with a current presumptive or positive COVID-19 case.

- An exposure is defined as an individual who has close contact (less than six feet) for longer than 15 minutes with a COVID-19 case.
- A presumptive case is defined as a person who was exposed to a positive COVID-19 case and developed symptoms.
- The exposed person must quarantine for 14 days. Start counting 14 days from the last time they had contact with the person with the presumptive or positive COVID-19 case.
- For presumptive cases only, if the exposure was to a presumptive case of COVID-19, exclusion is required only if the adult or child was exposed in the 10 days after the COVID-19 presumptive person started having symptoms. This is the period they would be infectious.

If a person develops these symptoms while at the facility or learns they have been exposed to a positive case while at the facility, send them home as soon as possible, and separate them until they can leave the facility.

If a child or staff member has symptoms of diarrhea, vomiting, headache, sore throat, or rash, they must be excluded and advised to consult a medical professional.

- If seen by a medical professional and is cleared, they can remain in or return to the program following the documented direction of the medical professional.
- If not seen by a medical professional, they may return 24 hours after resolution of symptoms.

11.6 Anyone who comes into child care who has a household member with symptoms of COVID-19 that is not confirmed or presumptive must be carefully monitored for symptoms. The ill household member should be strongly encouraged to get tested.

Requirements, Confirmed Case of COVID-19

During COVID-19, a child care and early education program must:

11.7 Notify the local public health authority and the Office of Child Care if anyone who has entered the facility, including household members within a family child

Responding to Possible and Confirmed Cases of COVID-19

care facility, is diagnosed with COVID-19. A program shall immediately contact their local public health authority and licensing specialist (alternatively, the program can call (503) 947-1400).

To locate your local public health authority, visit https://www.oregon.gov/oha/PH/ProviderPartnerResources/LocalHealthDepartmentResources/Pages/lhd.aspx.

11.8 Notify the appropriate program staff, in addition to the local public health authority and the Office of Child Care if you are a program that participates in:

ERDC: dpu.providerreporting@dhsoha.state.or.us or 800-699-9074.

Baby Promise, Preschool Promise, or Oregon Pre-Kindergarten program: Angela.Stinson@ode.state.or.us or 503-940-4198.

11.9 Communicate, in coordination with local public health authority, with all families and other individuals who have been in the facility in the past 14 days about the confirmed case.

11.10 Ensure, in the event of a confirmed case of COVID-19 in a facility, all children and staff in the stable cohort–and anyone who came in contact with the group–do not come to the program and are informed about the need to be quarantined at home for 14 days.

11.11 Decisions about required closure will be made in conjunction with ELD staff and the local public health authority.

Recommendations

The following practices are suggested to enhance health and safety:

A. Sign up for OHA's COVID-19 newsletter: https://www.govstatus.egov.com/OR-OHA-COVID-19.

Transportation

Requirements

During COVID-19, a child care and early education program must:

12.1 If transporting children, create a transportation plan that meets the following requirements and is developed and shared with staff and families.

Transportation plans must comply with all applicable state and federal guidelines.

Program transportation plans must include the following:

- Protocols for health screenings for staff and children.
- Personal Protective Equipment requirements.
- Cleaning and sanitizing schedule and documentation.
- Transportation schedule that minimizes the time each child is in transport.
- Procedures for communicating with families and staff about any updates, additional health information, and any changes to the transportation protocols.
- Procedures to send sick children who utilize transportation home.

12.2 Ensure children who become sick during the program participation be sent home immediately and not be transported in the same vehicle used to transport children in the program.

12.3 Require transportation only be provided to one stable group of children; this group may be different from the stable groups implemented within the facility.

12.4 Require transportation staff to follow health protocols upon reporting to work using the "Daily Health Check" included in this guidance.

12.5 Require transportation staff to adhere to exclusion rules.

12.6 Require transportation staff to wear face shields or face coverings.

12.7 Ensure staff follow all Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) guidance for the safe and appropriate transport of children.

12.8 Require an adult to bring children to the vehicle; the adult must remain until after the daily health check.

12.9 Conduct a daily health check as described in "Daily Health Check" section of this guidance prior to the child getting on the bus. Verification of the daily health check must be recorded.

12.10 Develop and implement procedures to require physical distancing between staff and adult(s) dropping off child.

Transportation

12.11 Assign children to the same location and seat each day. A seating chart must be developed and clearly displayed for all transportation staff.

12.12 To reduce person-to-person transmission, transportation staff must ensure children are at least three feet apart during transport.

12.13 Children must get out of the vehicle in a manner that minimizes children passing each other (e.g., unload from front to back of vehicle).

12.14 Staff must use hand sanitizing spray or gel (containing between 60-95% alcohol) in between helping each child and when getting on and off the vehicle.

12.15 Staff and children must wash hands as they enter the facility.

12.16 Immediately following each transportation session, clean and sanitize entire transportation vehicle, paying particular attention to frequently touched surfaces, such as seats/car seats, steering wheel, door handles, handrails, seat belts, air vents, and the top of seats. Sanitation products must be approved by the EPA for use against SARS-CoV-2: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19.

Recommendations

The following practices are suggested to enhance health and safety:

A. Programs providing transportation may want to build classroom enrollment based on transportation needs to minimize crossover interactions between children.

B. The adult dropping off children for transportation should be a household member.

C. Air circulation should be prioritized. Weather permitting and assuming that it does not pose any other risks to children (e.g., children with sensory issues), windows should be kept open. If not possible, internal ventilation systems should be used.

13

Professional Development

Requirements

During COVID-19, a child care and early education program must:

13.1 Ensure all necessary staff have first aid and CPR training. Online-only training will be accepted through July 2021 for recertification.

13.2 Provide access to professional development that contributes to staff's professional learning goals and to meet child care licensing or program requirements.

13.3 Ensure staff have resources necessary to participate in online courses or remote training.

13.4 In-person training is strongly discouraged. If considering in-person training, make sure the person or organization providing the training has received prior approval from the ELD for 1) any in-person training, and 2) meets professional development requirements.

Exception: Prior approval is not required for in-person training if all participants work at the same child care or early education facility or are within the same household and do not work at additional facilities and:

- The training happens within the facility where staff work.
- Does not disrupt stable groups of children and staff.
- Attendance does not exceed the state's requirements for group gatherings relevant to that county, or, for coaching or in-class/program observations, only one additional adult enters the room.
- Physical distancing is maintained throughout the entire experience.
- Face shields or face coverings are worn by participants.

13.5 All staff must review these guidelines, "Health & Safety Guidelines for Child Care and Early Education Operating During COVID-19," as well as any updates to the guidelines that occur, prior to implementation, including new hires prior to first day of work or during employee orientation.

Professional Development

Recommendations

The following practices are suggested to enhance health and safety:

A. Provide access to digital literacy training for staff to support online learning for themselves, children, or families.

B. Provide access to professional development around mental health and supporting resilience for oneself, families, and children that is culturally relevant to staff and families.

C. Support any trainers, coaches, or other professional development staff on adapting supports through distance methods.

COVID-19 Health and Safety Plan

Requirements

During COVID-19, a child care and early education program must:

14.1 Create a written "COVID-19 Health and Safety Plan" for each facility. (This is different from, or in addition to, an emergency preparedness or other plan already required by licensing rules.)

14.2 Ensure any information related to the facility's "COVID-19 Health and Safety Plan" is provided to families in a manner that they can understand.

14.3 ELD will provide an optional template for use in the creation of the "COVID-19 Health and Safety Plan." If you choose not to use the template, you must include all of the required elements that are identified in the template.

14.4 The "COVID-19 Health and Safety Plan" shall include a focus on training and communication with staff and families associated with the facility. A child care facility's "COVID-19 Health and Safety Plan" shall be shared with all families and staff and posted in an easily visible area.

14.5 Each child care facility must continue to monitor its "COVID-19 Health and Safety Plan" throughout the year and update as needed. All revisions must be shared with all families and staff and posted in an easily visible area.

14.6 The "COVID-19 Health and Safety Plan" must be completed within 45 days of ELD's issuance of the template for the "COVID-19 Health and Safety Plan."