

The decision to resume or expand in-person learning is complex and requires weighing both risks and benefits to children, staff, their families, and the broader community. With regards to COVID-19, DOH recommends that local leaders consider COVID-19 activity level (i.e., case rates, percent test positivity, trends, etc.) as well as the educational, social and emotional benefits of in-person learning for students. When recommending guiding metrics to resume in-person learning, DOH considered both the health risks of COVID-19 to students, school staff, and the surrounding community; as well as the benefits of in-person school to children and their families. These metrics are not intended to serve as a hard thresholds but as a primary consideration in determining for whom to provide in-person learning.

For whom should your community provide in person learning?

For School Administrators, Local Health Officers, and Community Stakeholders

The risk of COVID-19 being introduced into the school and spreading depends on the health and safety measures taken by schools and the level of COVID-19 spread in the community. Consider the following educational modalities based on community transmission and other health and education risks and benefits.

COVID-19 Activity	HIGH >350 cases/100K/14 days Test positivity >10% Trends in cases and hospitalizations	MODERATE ~50-350 cases/100K /14 days Test positivity 5-10% Trends in cases and hospitalizations	LOW <50 cases/100K/14 days Test positivity <5% Trends in cases and hospitalizations
Education Modality	<p>Phase in in-person learning in groups of 15 or fewer students for pre-K through grade 5 and those with highest needs.</p> <p>Prioritize Pre-K through grade 3, and students in any grade with disabilities, students living homeless, or those farthest from educational justice.</p> <p>If schools can demonstrate the ability to limit transmission in the school environment, add grades 4-5.</p>	<p>Phase in in-person learning.</p> <p>Prioritize Elementary (pre-K - 5) if they are not already receiving in-person learning, and Middle School.</p> <p>If schools can demonstrate the ability to limit transmission in the school environment, add more high school students when case rates are below about 200/100K/14 days.</p>	<p>Provide in-person learning for all students.</p>
Extra-curricular Activities	<p>Cancel or postpone most in-person extra-curricular activities except those allowed under Safe Start and Governor’s proclamations on COVID-19.</p>	<p>Extra-curricular activities must follow K-12, applicable Safe Start protocols and Governor’s proclamations on COVID-19.</p>	<p>Extra-curricular activities must follow K-12, applicable Safe Start protocols and Governor’s proclamations on COVID-19.</p>
Transition	<p>Across all COVID-19 Activity Levels:</p> <ul style="list-style-type: none"> • When trends in cases and hospitalizations are flat or decreasing, and the school can demonstrate the ability to limit transmission in the school environment, expand access to in-person learning • When trends are increasing, pause expansion of additional in-person learning and maintain access to in-person learning for those who have it. Schools are not required to reduce in-person learning or revert to remote learning based on metrics if the school can demonstrate the ability to limit transmission in the school environment. • Consider other health and education risks and benefits to children and their families <p>At any COVID-19 level, transition temporarily to full distance learning for 14 days when school meets criteria in DOH’s K-12 Health and Safety Guidance (p 16) or on recommendation of the local health officer.</p>		

Tools to Prepare for Provision of In-Person Learning among K-12 Students at Public and Private Schools during the COVID-19 Pandemic

Summary of December 16 changes:

- The Department of Health (DOH) revised the metrics to inform local decisions around the provision of in-person learning and the risk of transmission of COVID-19 in school environments. These revisions were based on emerging research and data gathered by state and national officials.
- These changes include revisions to the COVID-19 incidence rates to consider when making decisions about who to prioritize in-person learning for and further clarification that local leaders should consider test positivity and trends in cases and hospitalizations to inform decisions around in person learning.
- DOH defined a maximum ‘small group’ size of 15 for learning when disease activity is high and defined our ‘youngest learners’.
- DOH moved away from a ‘decision tree.’ This toolkit now includes two checklists that ensure readiness to implement all required [DOH Health and Safety Measures](#) and [LNI requirements](#), and a matrix that summarizes our recommendations for the provision of in-person learning based on the community’s metrics. The introduction and background sections were updated to reflect the rationale for the changes.

Introduction

This framework can assist local health officers in guiding and school administrators in deciding whether to resume, expand, or reduce in-person instruction for public and private K-12 schools during the COVID-19 pandemic. This tool is added to the Department of Health’s (DOHs) [K-12 Fall Health and Safety Guidance](#). Both will continue to be updated as the COVID-19 pandemic evolves and additional scientific information is available.

School administrators face challenging decisions about how to operate their schools during a pandemic, and they should consult with their local health officer, local elected leaders, teachers, school staff, families, and other stakeholders. DOH recommends that school administrators weigh the risks and benefits to students, families, staff, and their communities when deciding which mode of education to use. They should consider rates and trends in COVID-19 cases and hospitalizations and test positivity in their community along with other health and education risks and benefits to children and their families. In making these difficult decisions, school administrators should also engage staff and families of students at risk for severe COVID-19, families of students with disabilities, English language learners, students living in poverty, students of color, and families of young students to determine how to best meet the health and education needs of these students and the community.

While DOH encourages local health officers and school administrators to work together to evaluate the public health considerations regarding in-person learning during the COVID-19 pandemic, school

administrators are ultimately responsible for establishing appropriate education services. The local health officer should advise the school administrator and the school community on the level of COVID-19 activity, the community's access to testing, and the health department's capacity to respond to cases or outbreaks in schools with timely investigations and contact tracing.

Local health officers are responsible for controlling the spread of communicable disease like COVID-19 in the community. County-level COVID-19 activity is measured by key health indicators including the number of cases per 100,000 people over a 14-day period, the percentage of positive tests, trends in cases or hospitalizations, and other measures, such as outbreaks and age-specific impacts. The local health officer should ensure information on key indicators is available to inform school administrators and the public. You can also find county and statewide indicators on [Washington's Risk Assessment Dashboard](#) (cases per 100K over 14 days and percentage of positive tests) and [Department of Health's COVID-19 Dashboard](#) (epidemiologic curves for cases and hospitalizations). The local health jurisdiction may further disaggregate these indicators, or use other data to guide recommendations for in-person learning.

School administrators must cooperate with investigations, directives, and orders made by the local health officer ([WAC 246-101-420](#)). If a local health officer determines that the opening of a school or the continuation of in-person learning poses an imminent public health threat to the community, they have the legal power and duty to direct or order an interruption of in-person learning ([WAC 246-110-020](#)).

Background

To inform the first version of this guidance published this summer, DOH reviewed the experiences of countries that resumed some degree of in-person instruction this spring. These countries generally had low and decreasing community rates of COVID-19 cases. The incidence rates in several countries that successfully resumed in-person instruction were below 50 cases per 100,000 population per 2 weeks.¹

In addition to having lower and decreasing community rates of disease, these countries took a very cautious approach to resuming in-person instruction. Most countries first resumed in-person instruction for a portion of their students, and many implemented health and safety measures like physical distancing, frequent hand washing, use of face coverings, and frequent environmental cleaning to reduce the spread of COVID-19 in the schools.²

Based on these data, DOH previously recommended cautiously phasing in in-person learning when county incidence rates fell below around 75 cases per 100,000 population per 2 week period. With rates above this threshold, schools could consider bringing back students with special needs and the youngest learners. In all cases, schools must implement the COVID-19 safety and prevention measures recommended by DOH.

Early experience and learning from the United States

This fall, most schools across the country and some schools in Washington resumed some degree of in-person learning. While no national entity is rigorously studying data from across the country, a team of

¹ Kaiser Family Foundation "What Do We Know About Children and Coronavirus Transmission?" website accessed on August 2, 2020 at: <https://www.kff.org/coronavirus-covid-19/issue-brief/what-do-we-know-about-children-and-coronavirus-transmission/>

² Summary of School Re-Opening Models and Implementation Approaches During the COVID 19 Pandemic. July 6, 2020. Available at: <https://globalhealth.washington.edu/sites/default/files/COVID-19%20Schools%20Summary%20%28updated%29.pdf>

researchers and students at Brown, MIT, Harvard, Massachusetts General and other institutions have enrolled over 5,000 schools with more than 3.9 million students participating in in-person learning to voluntarily share their data on the number of COVID-19 cases and outbreaks in their school.³ Case rates for COVID-19 among students and staff trend similarly to the surrounding community rate, meaning when community rates increase, so do staff and student rates, with student rates typically lower than community rates. During the period of August 31 to November 22, 2020, these data show that the proportion of students and staff with confirmed COVID-19 was 0.22% and 0.42% respectively. During the period of November 9-22, among schools providing either full or hybrid in person learning, 5.4% of all schools reported an outbreak involving five or more cases and 1.5% of schools reported an outbreak involving 10 or more cases.

States have taken a range of approaches. California allows in-person learning when counties have fewer than 98 cases per 100,000 over 14 days.⁴ Oregon recently updated their school metrics, and now recommends in-person instruction when counties have fewer than 50 cases per 100,000 population over 14 days. When counties have between 50 and 100 cases, Oregon recommends phasing in of onsite or hybrid learning, starting with elementary students. Counties must switch to comprehensive distance learning with limited in-person instruction when they exceed 200 cases per 100,000 population over 14 days.⁵ Massachusetts prioritizes in-person learning for all students if feasible when COVID-19 rates are less than 140 cases per 100,000 population over 14 days (in this range, hybrid models are allowed only if necessary to meet health and safety requirements); when COVID-19 case rates are higher than this, Massachusetts recommends hybrid learning that maximizes in person learning for high needs students.⁶ Arizona recommends in person learning at or below 20 cases per 100,000 population over 14 days, hybrid learning between 20 and 200 cases per 100,000 population of 14 days, and primarily remote learning at 200 cases per 100,000 over 14 days.⁷ West Virginia shifts to primarily remote learning at 210 cases per 100,000 population over 14 days.⁸ Colorado encourages in-person learning when there are

³ Accessed from <https://covidschooldashboard.com/> on November 18, 2020

⁴ Blueprint for a Safer Economy website. California Department of Public Health. Accessed on November 19, 2020. <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID19CountyMonitoringOverview.aspx>

⁵ General Metrics for Returning to In-Person Instruction Through the On-Site or Hybrid Model. Oregon Department of Education website accessed November 17, 2020. <https://www.oregon.gov/ode/students-and-family/healthsafety/Documents/Following%20the%20Metrics%20Visual.pdf>

⁶ Updates to Guidance on Interpreting DPH COVID-19 Health Metrics website accessed on November 17, 2020. <https://www.doe.mass.edu/covid19/on-desktop/interpreting-dph-metrics.html#iii>

⁷ Safely Returning to In Person Instruction, Arizona Department of Health Services. Accessed November 19, 2020. <https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/novel-coronavirus/covid-19-safely-return-to-in-person-instruction.pdf>

⁸ West Virginia School Reentry Metrics and Protocols website. West Virginia Department of Education. Accessed November 19, 2020 <https://wvde.us/school-reentry-metrics-protocols/>

State	Rates of COVID-19 Cases per 100,000 population over 14 days*		
	In-Person Learning	Hybrid, Phased, or Transitional	Remote Learning for most or older students
Arizona	<20	20-200	>200
California	≤98		>98
Colorado	<75	75-350**	>350**
Massachusetts	<140	≥140	
Minnesota	<100	100-500	>500
Oregon	<50	50-200	>200
Washington	<50	50-350	>350
West Virginia	<210		≥210

Table 1: State Metrics for Learning Modality among States

*some states have daily or weekly case rates for metrics. Above are adapted to the approximate rate per 100K per 14 days. States may also have additional metrics.

** Colorado suggests in-person for K-5 at moderate and high levels, with the option to provide hybrid or distance learning. At the high level, in-person remains an option for middle school.

fewer than 75 cases per 100,000 population over 14 days. It suggests in-person learning up to 350 cases per 100,000 over 14 days with the option to provide hybrid or distance learning. Above 350 cases per 100,000 over 14 days, Colorado suggests in-person learning for K-5 with the option to provide hybrid and distance learning, the option of in-person, hybrid, or remote learning for middle school, and hybrid or remote learning for high school.⁹ Minnesota uses a staggered approach for K-12 students beginning at 100 cases per 100,000 population over 14 days, using local epidemiological information and the health and safety provisions of the school, to move from in-person elementary and hybrid secondary, through hybrid elementary and distance-learning for secondary, to fully distance-learning at 500 cases per 100,000. Once a school has opened, they tailor the learning model based on the presence of cases in the school community.¹⁰

Early experience and learning in Washington state

In Washington state, the majority of public school districts are providing some in-person learning, however, most of Washington’s 1.1 million public school students have been learning remotely. According to data from the Office of the Superintendent of Public Instruction (OSPI) and the Association of Educational Service Districts (AESD), as of October, 91% of Washington public school students live in districts that are providing some level of in-person learning. However, in most districts, in-person learning is limited to small group instruction of the youngest elementary students or students with special needs.

According to data from OSPI and AESD, as of October, 115 school districts were providing in-person learning to more than half of their students. These 115 school districts serve approximately 11% of Washington’s public school students. In contrast, about 90% of Washington’s 73,000 private school students are in full or hybrid in-person learning. Similar to national data, Washington state outbreak data also show that, while cases and outbreaks do occur in schools, recognition of transmission of COVID-19 has been limited in the school setting.

⁹ COVID-19 Risk dial. State of Colorado website. Accessed December 13, 2020. <https://covid19.colorado.gov/covid-19-dial>

¹⁰ Safe Learning Plan for 2020-2021: A Localized Data-Driven Approach. Accessed August 1, 2020 at: https://mn.gov/covid19/assets/safe-learning-plan_tcm1148-442202.pdf

Local public health has reported a total of 88 K-12 school outbreaks to DOH since the start of the pandemic through December 12, 2020; 84 of which have occurred since August 1, 2020.

A total of 266 cases have been linked to the 84 outbreaks. Among these cases, 48% were among children. Cases were distributed evenly across child age groups. The age distribution of cases appears in Table 2.

While COVID-19 does get introduced into school environments, the health and safety measures being taken within schools seem to be limiting the spread of the infection in the school. The number of school outbreaks is larger in counties with higher community transmission, however the size of outbreaks is, on average, small (Table 3). Half of the outbreaks in K-12 schools have 3 or fewer cases linked. Among outbreaks since August 1, 15 involve five or more cases, 2 of those involve ten or more cases. The two largest outbreaks each have 11 cases linked to them and occurred in private schools.

Age in years	Percent of Cases linked to K-12 Outbreaks
5-9	17%
10-14	16%
15-19	15%
20-39	15%
40-59	29%
60+	8%

Table 2: Age distribution of cases linked to K-12 outbreaks in Washington reported Aug 1, 2020 through December 12, 2020.

Table 3: Rates of COVID-19 cases per 100, 000 population over 2 weeks and K-12 school outbreaks in Washington reported Aug 1, 2020 through December 1, 2020.

Rates of COVID-19 cases per 100K/14 days	All Outbreaks		Smaller Outbreaks (Less than 5 cases)		Larger Outbreaks (More than 5 cases)	
	N	%	N	%	N	%
Low (<50)	5	6	5	8	0	0
Moderate (50-349)	65	82	52	81	13	87
High (>350)	9	12	7	11	2	13

It is important to note that the experience of hybrid or in person learning in Washington schools has occurred in the setting of relatively low community transmission rates compared to other states. As community transmission rises, more cases will likely be introduced into schools. In addition, because children are less often symptomatic, some cases have likely gone unrecognized.

In addition to experiences in Washington and the United States, a recent literature review by the University of Washington and models from the Institute for Disease Modeling (IDM) suggests that the risk of transmission in K-12 schools depends on the incidence of COVID-19 infections in the community as well as school-based countermeasures.^{11,12} A follow up report from IDM found that risks could be

¹¹ University of Washington. Summary of Evidence Related to Schools during the COVID-19 Pandemic Updated October 19, 2020. Accessed November 29, 2020. Available at https://depts.washington.edu/pandemicalliance/wordpress/wp-content/uploads/2020/10/COVID-19-Schools-Summary_2020_10_19.pdf

¹² Institute for Disease Modeling. Schools are not islands: we must mitigate community transmission

significantly mitigated through hybrid school schedules or via a phased-in approach that brings back K-5 first.¹³ A third modeling study found that *when R effective is already at 1* in the surrounding community (meaning, disease levels are stable and not increasing or each person who has COVID-19 on average, infects one other person), reopening schools will not significantly increase community-wide transmission, provided sufficient school-based interventions are implemented, such as masking, physical distancing, and screening students and staff for symptoms. The use of hybrid scheduling further reduces the infection rate.¹⁴

Summary and Recommendations

Taken together, the science and early experience of schools in Washington state and across the nation suggest that rigorous health and safety measures can limit transmission of COVID-19 in the school environment. DOH recommends comprehensive and strict [health and safety measures \(PDF\)](#) to minimize the risk of transmission within schools, and Proclamation 20-09.3 requires schools to implement them. These measures include all five of CDC's key mitigation strategies.¹⁵ Checklists that summarize these requirements follow on the next page.

Given this, DOH recommends continued, cautious in-person learning can occur at community COVID-19 rates higher than established in the initial versions of this framework. The updated case rates in this version reflect DOH's best estimate of appropriate parameters given these findings.

- **High COVID-19 activity:** At this level, DOH recommends in person learning for pre-K through grade 5. Schools should prioritize the youngest learners—pre-K, Kindergarten, and grades 1-3—and those with the highest needs (from any grade), such as students with disabilities, students living homeless, or those farthest from educational justice, using small group instruction of 15 or fewer students and strict cohorting due to the level of community transmission. Then phase in grades 4-5, similarly in small groups.
- **Moderate COVID-19 activity:** At this activity level, DOH recommends careful phasing in of in-person learning starting with any elementary students not already in-person and middle school students. Then over time, adding high school after middle school and when rates drop below 200 cases per 100,000 over 14 days.

Low COVID-19 activity: At this activity level, DOH recommends the provision of in-person learning for all students, prioritizing full time in-person learning for elementary students. If space allows, full time in-person learning can be added for middle and high school students.

to reopen schools. Accessed November 29, 2020. Available at https://covid.idmod.org/data/Schools_are_not_islands_we_must_mitigate_community_transmission_to_reopen_schools.pdf

¹³ Institute for Disease Modeling. Maximizing education while minimizing risk: priorities and pitfalls for reducing risks in schools. Accessed November 29, 2020. Available at https://covid.idmod.org/data/Maximizing_education_while_minimizing_COVID_risk.pdf

¹⁴ Institute for Disease Modeling. Testing the Waters: is it time to go back to school. Accessed November 29, 2020. Available at https://covid.idmod.org/data/Testing_the_waters_time_to_go_back_to_school.pdf

¹⁵ Centers for Disease Control and Prevention. Indicators for School Decision-Making website. Accessed December 15, 2020. Available at <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/indicators.html>

Can the school(s) implement recommended COVID-19 health and safety measures?

School Administrators and Staff

The risk of COVID-19 spreading in schools depends on the ability of the school to implement **DOH's K-12 health and safety measures** and [LNI employer safety requirements](#).

Does the school have the plans, staff, space, and supplies to do the following?

- ✓ Protect staff and students at higher risk for severe COVID-19 while ensuring access to learning.
- ✓ Transport or facilitate drop-off and pick-up of students.
- ✓ Group students (required in elementary, recommended for middle and high school).
- ✓ Practice physical distancing of ≥6 feet among students and staff.
- ✓ Promote frequent hand washing or sanitizing.
- ✓ Promote and ensure face covering use among students and staff.
- ✓ Increase cleaning and disinfection.
- ✓ Improve ventilation.

Are all staff trained on health and safety practices?



Is the school and health system ready to monitor for and respond to suspected and confirmed cases of COVID-19?

Schools and Local Public Health

COVID-19 cases in the school should be expected. The risk of COVID-19 spreading in schools depends on the ability to quickly identify and respond to suspected and confirmed cases and the level of community transmission.

- ✓ Can **the school** ensure monitoring of symptoms and history of exposure among students and staff? (attestation acceptable)
- ✓ Is **the school** prepared to manage students and/or staff who get sick onsite?
- ✓ Does **the school** have letters drafted to inform families and staff about confirmed cases or outbreaks? For other languages?
- ✓ Is there adequate access to testing in the community **health** system for ill students and staff?
- ✓ Is there capacity in your **local health department** to investigate confirmed COVID-19 cases, quarantine their close contacts and assess whether transmission is occurring in the school?
- ✓ Can **local public health** monitor the level of community spread to determine when a change in education modality is needed?



Begin Learning Model and Monitor

Health risks of COVID-19 to students, school staff, and the community

The risk of COVID-19 entering schools depends on the mitigation measures in place at the school and the level of COVID-19 spread in the community. At this time, any degree of in-person instruction presents some risk of infection to students and staff. It is not possible to predict the number of infections that might occur under different in-person models and levels of transmission in the community with certainty, but higher levels of community transmission will generally result in a higher risk of COVID-19 being introduced into the school environment. **DOH recommends and Governor's Proclamation 20-09.3 requires comprehensive and strict [health and safety measures \(PDF\)](#) to minimize the risk of transmission within schools.**

The full spectrum of illness due to COVID-19 is not fully understood. While children generally have mild COVID-19 disease, serious infections have occurred¹⁶. Teachers and school staff are at risk for more serious disease, especially older adults and those with [certain underlying health conditions](#). Students and staff that acquire COVID-19 at school can transmit to others in the school setting as well as to their households and their contacts in the community.

Beyond COVID-19 infections, the pandemic has brought other health concerns. Recent data from the CDC show the proportion of emergency department visits related to mental health crises has increased for young children and adolescents since the pandemic started. From this March through October, while the overall number of children's mental health-related ED visits decreased, the proportion of all ED visits for children's mental health-related concerns increased, reaching levels substantially higher beginning in late-March to October 2020 than those during the same period during 2019.¹⁷

Benefits of school for children

In-person learning has a broad range of benefits for our children. In addition to educational instruction, schools support the development of social and emotional skills; create a safe environment for learning; address nutritional, behavioral health and other special needs; and facilitate physical activity¹⁸. The absence of in-person learning may be particularly harmful for children living in poverty, children of color, English language learners, children with diagnosed disabilities, and young children, and can further widen inequities in our society¹⁹.

A narrative review of multiple studies made recommendations for addressing child and adolescent mental health during the pandemic. It noted the importance of face-to-face learning and recommended

¹⁶ Götzinger F, Santiago-García B, Noguera-Julián A, et al. COVID-19 in children and adolescents in Europe: a multinational, multicentre cohort study. *Lancet Child Adolesc Health* 2020.

<https://www.thelancet.com/action/showPdf?pii=S2352-4642%2820%2930177-2>.

¹⁷ Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1675–1680.

DOI: [http://dx.doi.org/10.15585/mmwr.mm6945a3external icon](http://dx.doi.org/10.15585/mmwr.mm6945a3external%20icon)

¹⁸ CDC. The Importance of Reopening America's Schools this Fall. Accessed August 1, 2020 at

<https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/reopening-schools.html>

¹⁹ Levinson M, Phil D, Cevik M, Lipsitch M. Reopening Primary Schools during the Pandemic. *New Eng J Med* 2020. <https://www.nejm.org/doi/full/10.1056/NEJMms2024920>

school reentry policies consider strict social distancing and hygiene measures, keeping in mind the importance of in-person learning for children in the school set-up.²⁰

Following a review of school re-openings in multiple countries during COVID-19, a group of public health and education experts at Harvard, recommended that primary school be deemed essential.¹⁹ Because of the critical role, schools play in children’s physical, developmental, and mental health, CDC recently recommended that K-12 schools should be the last settings to close after all other mitigation measures have been employed and the first to reopen when they can do so safely.²¹

Conclusion

This framework can assist local health officers in guiding and school administrators in deciding whether to begin, expand, or reduce in-person instruction for public and private K-12 schools during the COVID-19 pandemic. It can also help ensure the school is able to implement comprehensive health and safety measures and respond swiftly if a person with confirmed COVID-19 is identified in the school environment.

In-person learning should be prioritized for elementary school students because they may be less likely to spread COVID-19 than older children²², have more difficulty learning asynchronously, and may otherwise need to be in a childcare setting if their parent(s) or primary caregiver(s) work. DOH favors a cautious, phased-in approach to resuming in-person instruction, especially at high rates of disease. DOH recommends that schools start with staff, small groups of our youngest learners (pre-Kindergarten, Kindergarten, and grades 13), and students who are unable to learn or receive critical services asynchronously. Over time, schools can add additional students to in-person models.

While important to a child’s growth and development, DOH prioritizes educational opportunities over extra-curricular activities in schools or other activities in the surrounding community.

More COVID-19 Information and Resources

Stay up-to-date on the [current COVID-19 situation in Washington](#), [Governor Inslee’s proclamations](#), [symptoms](#), [how it spreads](#), and [how and when people should get tested](#). See our [Frequently Asked Questions](#) for more information.

A person’s race/ethnicity or nationality does not, itself, put them at greater risk of COVID-19. However, data are revealing that communities of color are being disproportionately impacted by COVID-19- this is due to the effects of racism, and in particular, structural racism, that leaves some groups with fewer

²⁰ Singh, S., Roy, D., Sinha, K., Parveen, S., Sharma, G., & Joshi, G. (2020). Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. *Psychiatry research*, 293, 113429. <https://doi.org/10.1016/j.psychres.2020.113429>

²¹ Honein MA, Christie A, Rose DA, et al. Summary of Guidance for Public Health Strategies to Address High Levels of Community Transmission of SARS-CoV-2 and Related Deaths, December 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1860-1867. DOI: <http://dx.doi.org/10.15585/mmwr.mm6949e2>

²² 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. <https://doi.org/10.3201/eid2610.201315>

opportunities to protect themselves and their communities. [Stigma will not help to fight the illness.](#) Share accurate information with others to keep rumors and misinformation from spreading.

- [WA State Department of Health 2019 Novel Coronavirus Outbreak \(COVID-19\)](#)
- [WA State Coronavirus Response \(COVID-19\)](#)
- [Find Your Local Health Department or District](#)
- [CDC Coronavirus \(COVID-19\)](#)
- [Stigma Reduction Resources](#)

Have more questions about COVID-19? Call our hotline: **1-800-525-0127**, Monday – Friday, 6 a.m. to 10 p.m., Weekends: 8 a.m. to 6 p.m. For interpretative services, **press #** when they answer and **say your language**. For questions about your own health, COVID-19 testing, or testing results, please contact a health care provider.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.