

# Information for Schools regarding the medical management of children attending childcare, kindergarten or school

## Preamble

A working group was set up comprising representative specialists in Family Medicine, Paediatrics and Public Health Medicine working in both the public and private sectors in order to reach a common evidence-based position on the management of children with COVID-19 - like and Influenza-like symptoms in the current reality of COVID-19 spread in Malta.

## Aim

The aim of this document is to provide information to school administrators and parents on how the implementation of these clinical decisions will impact sickness policy in school, school absence certification and certification for shielding for children. It does not cover the medical management of adults/staff.

## General

Any staff member (educator/ administration staff/ other) or child who feels unwell or has any symptoms should **not** attend school. This is likely to be the single most important measure to prevent the spread of COVID-19 (and influenza) in the school community and keep all safe.

Many children with COVID-19 do display symptoms, with the most common of these being fever and cough. Other symptoms include tiredness, sore throat, runny / blocked nose, headache, muscle pain and loss of smell and taste. Vomiting and diarrhoea are also important symptoms that are also more common in children. A percentage of children are also asymptomatic, thus the importance of the other mitigation measures implemented in schools to minimize spread.

Current information on the transmission of COVID-19 has shown that transmission amongst school children is low and that children are more likely to contract COVID-19 from a household member or from an adult rather than from another child

One should be increasingly wary to suspect COVID-19 if a child has an adult household member who also has symptoms of acute respiratory illness.

## FAQs

### **If my child is found to have fever on screening at school entrance what should I do?**

If your child is sent home for having an elevated screening temperature on school entry but has no other symptoms and is otherwise well, inform your doctor and keep your child at home and measure their fever using a digital thermometer (either orally or axillary) every 6 hours without giving them any medicines which decrease temperature (such as paracetamol or ibuprofen). If after 24 hours the child has no fever, your doctor can certify your child well to attend school the next day. If he/she develops any symptoms discuss the next steps to be taken with your doctor.

### **If my child is sick, what should I do?**

If you notice that your child is unwell whilst at home or has been sent home from school, it is recommended that you seek the advice of your doctor. This communication should initially take place by virtual means either on the phone or else through a virtual consultation. According to the information provided, the doctor will decide on what further action is necessary including on whether your child should be booked for a swab test or not.

### **If someone is sick at home, should I still send my child to school?**

As a general rule, if someone is sick at home, but your child has absolutely no symptoms, then he/she can attend school normally unless otherwise instructed by the doctor.

### **Who will provide a medical certificate for my child to be able to return to school?**

A medical certificate to enable your child to return to school after sickness is required from your doctor. This certificate will provide the date when the child can resume in-person learning. Please be aware that the child is expected to be free of symptoms for 48 hours before return to school and the date given on the certificate for return to school will take this into consideration. A medical certificate is required each time a child is absent from school due to sickness, even for one day. This may be changed depending on the general situation of COVID-19 in the country.

### **What happens if the child's symptoms get worse or the symptoms change after initial consultation with a doctor?**

In this case, if the course of recovery from illness is not that which was expected by your doctor, you should get in touch with your doctor again so that the situation can be re-evaluated.

## **After how many days of absence from school will my child require a medical certificate to return to school?**

During the spread of COVID-19 it was decided that every day of school absence due to medical reasons needs to be certified. The Medical Council currently considers virtual/phone/on-line consultations as an acceptable format for a medical encounter and allows the doctor, according to her/his clinical discretion, to determine whether a person to person encounter is necessary. Consequently, remote consultations are an acceptable means of providing certificates for school fitness and return to school. The medical certificates from the doctor may be on paper, on an sms or on e-mail.

## **Can the school request a negative swab test or any other test prior to allowing my child to return to school?**

No, the school cannot request or demand a negative swab result for the child to return to school. The school can only request a doctor's certificate which would state that the child is fit to return to school and that any acute or infective illness is now resolved. A sms or an email certifying school fitness is an acceptable means of certification.

## **My daughter was confirmed to have COVID-19 and we were instructed by the Public Health Authorities to remain indoors since we were placed in mandatory quarantine. Who will certify when she can return to school?**

As a confirmed case of COVID-19 your child will be placed in mandatory quarantine for **at least** 2 weeks as instructed by the Public Health Authorities. The Public Health team will be in touch periodically and will let you know when to re-test your child to check whether s/he has cleared the virus from her/his body. Upon receipt of this negative test, your child would be considered recovered. The Public Health team will provide documentation that can be passed on to the school. Your child can return to school with no other measures to be considered once s/he is recovered. A separate sick leave certificate is not required in this case.

## **My child was a close contact of a person diagnosed with COVID-19 and as a result, Public Health Authorities have placed us in mandatory quarantine. What certification can I show to the school in order to justify my child's absence?**

Persons who are identified as close contacts of positive cases are generally placed in mandatory quarantine together with their households. When they are contacted by Public Health, a Quarantine letter is issued with a start and an end date of quarantine. This letter can be presented to the school to certify the absence. The child can return to school on the day after the end of quarantine has been set and no additional measures or precautions are necessary in the school setting or in his/ her regard.

## **What is shielding?**

Earlier in the pandemic, based on the evidence available at the time, the Health Department issued a list of chronic conditions known as the 'vulnerable list'. Persons with these conditions were expected to remain at home and were given legal protection to do this. The legal basis for this decision was withdrawn at the end of May. Since then newer evidence has emerged and medical experts have determined that only a very restricted list of medical conditions in

children makes them clinically more susceptible to serious complications from a COVID-19 infection than the general population. This list is provided in Annex 1 and only the caring hospital consultant paediatrician can certify such children as requiring shielding.

If the hospital consultant paediatrician certifies that your child would warrant shielding, this does not mean that your child must necessarily forego attending school and must stay at home. This certification means that additional mitigation measures to decrease contact with others should be implemented to enable the child to still attend and learn from school. Each Hospital Consultant Paediatrician who cares for these children will be in touch with the family and provide them with a certificate for shielding.

It is the parents' responsibility to present this certificate to the school management following which a discussion should ensue on how to make the child's school attendance and experience safer.

Examples of additional shielding include:

- increasing the interpersonal distance of this particular child from others
- arranging the seating plan so there may be less interaction
- avoiding the use of school transport
- asking all the children in the class to wear a face covering (even if they are within the age group where this is not mandatory)
- considering physical barriers made of acrylic or tempered glass to surround child's desk
- meticulous enhanced general hygiene measures and hand sanitization.

These are examples of possible measures which can be taken. However, the feasibility and implementation of these additional measures need to be determined with School Management.

### **How will I know if my son/ daughter should be shielded?**

Only a restricted number of children warrant shielding and not necessarily all children with these listed conditions would require it. This depends on the present clinical condition of your child and also the spread of COVID-19 in the community. You will be contacted by the Hospital Consultant Paediatrician caring for your child and given a shielding certificate if this is indicated. In the annex to these FAQs the list of conditions for which a shielding certificate may be produced is included. If in doubt consult your family doctor, who would be able to discuss your concerns with the Hospital Consultant.

### **Is it safe for my children to be collected from school by their grandparents and for the children to be cared for by them whilst I am at work?**

These type of arrangements should be taken freely in discussion between the parents of the child and the grandparents. It is however important to point out that taking care of children who come into regular contact with other children does carry an increased risk, since children do have multiple social contacts in different settings and bubbles, such as at schools, at childcare centres, on school transport, and at extracurricular activities (e.g. sport, ballet, MUSEUM etc).

It is important that if grandparents are going to be caring for school-aged children for a number of hours a day, extra precautions should be taken since older persons and those with chronic illnesses are more likely to be severely affected if they had to contract COVID-19. Never leave children in the care of grandparents if they exhibit any symptoms of being sick. Masks should be worn if grandparents would be driving children to/from school. If they care for them for any prolonged time they should be extremely vigilant to avoid unnecessary close contact, maintain social distancing as much as possible, wear masks/visors at all times. Rooms should be adequately ventilated by opening the windows or spending time outdoors if possible. One should be careful to adopt very good hand hygiene and respiratory hygiene both for the children and the grandparents.

**There are a number of rapid pin-prick tests or rapid tests which are not the standard PCR tests for COVID-19. Are these reliable and would they be accepted as a swab test for my child who may get sick?**

It is important to emphasize that the antigen/antibody tests currently available on the market cannot replace the PCR swab test as a confirmatory test for COVID-19. These tests should not be used to determine if anyone is sick in view of COVID-19 or not. In the near future other tests may become available which would be accepted as a confirmatory test and in that case we will update our guidance accordingly. However, such tests would still need to be administered by a trained health care professional.

**My daughter suffers from frequent allergies/ suffers from asthma so she has an occasional cough. How can reassure the school that she does not have anything contagious?**

If your child has some long-term allergic symptoms or suffers from asthma, obtain a note from your doctor certifying that child does not have acute/ infective symptoms. This would reassure the School Management and avoid him/her being sent home unnecessarily. Any increase or change in the usual symptoms would warrant medical attention.

**If a person in my child's class has been identified has a positive case of COVID-19, will the whole class need to remain in quarantine for 2 weeks?**

When a positive case is found within a school, a risk assessment is performed by Public Health in conjunction with the COVID Liaison Officers of the school. This risk assessment is based on many factors, whether an adult or a child is the positive case, the age of the children in the classroom, whether they were wearing masks or not, whether the positive person had symptoms and the duration and proximity of contact between children amongst others factors. Following this assessment, it will be determined who needs to go into quarantine. This could range from nobody, to a few students in close contact to also the whole class if necessary. It is difficult to give a definite answer since this depends on these various factors. When a person is placed in mandatory quarantine, the household members would also need to remain in quarantine for the same period of time. School Management and the COVID Liaison Officers of each school have been provided the Contact Tracing Protocol for them to be in a better position to advise parents and staff accordingly.

## Annex 2 - Paediatric conditions that may necessitate shielding September 2020<sup>1</sup>

The following are paediatric conditions for which children may be asked to shield. Advice to shield depends mainly on community transmission of SARS-CoV-2 and public health advice on when extremely vulnerable or less vulnerable people should shield. Degree of vulnerability is not the same for all conditions listed below, and is also dependent on the severity of the condition which will be determined by the caring consultant.

Advice for shielding is also affected by:

- a) the complexity of the underlying condition,
- b) guidance given by the caring hospital consultant,
- c) age of the child, and the mental capacity of the child with respect to the ability to perform hand hygiene, respect social distancing and put on and take off a face mask safely and
- d) the capacities of schools to provide help with shielding of vulnerable children: schools need to be well prepared for this and work to provide inclusive education to all children irrespective of any underlying condition the child might have. There should be no form of discrimination against children who suffer from a condition that makes them vulnerable.

Conditions that may put children more at risk\* to COVID-19 are as follows:

***\*Not all children with these conditions have the same risk to COVID-19 and the need for shielding may vary depending on the epidemiology of SARS-CoV-2.***

---

<sup>1</sup> Based on Covid-19 –shielding guidance for children and young people. RCPCH: 22nd September 2020

### Immunodeficiency disorders

- Primary or secondary immunodeficiency disorders if on prophylactic antibiotics or immunoglobulins AND on immunosuppressants (such as steroids for >4 weeks, or biologics) OR with a concurrent co-morbidity (significant lung disease, renal impairment, chronic liver disease).
- Following a bone marrow transplant for a primary immunodeficiency disorder AND are still within 12 months of the transplant OR are on immunosuppressants or immunoglobulins or have significant lung disease or ongoing Graft versus Host disease.
- HIV infection AND with a CD4 count less than 200 or had an opportunistic infection within the last 6 months or have detectable viral load or are not on any antiretroviral treatment.

### Oncology

- Are on induction chemotherapy for Acute Lymphoblastic Leukaemia (ALL) or Non-Hodgkin's lymphoma or are on chemotherapy for Acute Myeloid Leukaemia (AML) or for relapsed and/or refractory leukaemia or lymphoma.
- Are post autograft transplant in the last 6 months or post allogeneic transplant within the last 12 months or until immune reconstituted.
- Are on CAR-T therapy or within 6 months from administration or until immune system has recovered.
- Are on chemotherapy for any cancer diagnosis or within 6 months of its completion or are on long term maintenance steroids.
- Have completed treatment for cancer but have ongoing significant respiratory, cardiac, renal or neurological conditions.

### Cardiology

- Fontan, single ventricle physiology, especially with evidence of failure, and or end organ damage.
- Persistent cyanosis (oxygen saturations <85% persistently)
- Pulmonary Arterial Hypertension (PAH) especially those on pulmonary vasodilator therapy.
- Infants under 1 year with unrepaired congenital heart disease requiring surgery or catheter intervention e.g. VSD, AVSD or tetralogy of Fallot.
- Severe cardiomyopathies requiring medication.
- Congenital heart disease on medication to improve heart function.

- Post heart transplantation.
- Congenital heart disease and significant co-existing conditions e.g. chronic kidney disease or chronic lung disease.
- Severe and or symptomatic heart failure, particularly those on heart failure therapy.

#### Dermatology

- High dose steroids, defined as  $\geq 0.5\text{mg/kg/day}$ , for at least 4 weeks, within the last 4 weeks.

#### Haematology

- Sickle cell disease with additional co-morbidities or with a history of at least one chest crises needing intensive care treatment or at least two chest crises necessitating treatment.
- Thalassaemia or other inherited or congenital anaemia with severe iron overload and additional co-morbidity.

#### Neonatal

- Ex-premature infants with continuing oxygen and/or intermittent non-invasive ventilation requirements.
- Any infant who is eligible for palivizumab.

#### Neurology

- Patients with significant difficulty with swallowing (e.g. myotonic dystrophy patients).
- Patients at significant risk of decompensation during infection (e.g. mitochondrial disease).
- Patients with symptomatic heart failure, particularly those on heart failure therapy (e.g. Duchenne muscular dystrophy).
- Patients with myasthenic syndromes.

#### Gastroenterology, Hepatology & Nutrition

- Paediatric inflammatory bowel disease (IBD) patients with ANY of the following:
  - Whilst on intravenous or oral steroids  $\geq 20\text{mg}$  prednisolone (or  $>0.5\text{mg/kg}$ ) or equivalent per day.
  - Have started biologic therapy plus immunomodulatory or systemic steroids within previous six weeks.
  - Have moderate to severely active disease not controlled by moderate risk treatments who may require an increase in treatment.



- Intestinal failure patients requiring Home Parenteral Nutrition (HPN) with any of the following:
  - Primary immunodeficiency or immunodeficiency induced by drugs as part of their therapy.
  - Other significant conditions or other organ involvement (renal, haematology, cardiac, GI, respiratory, diabetes mellitus).
  - Social cofactors (eg heavily reliant on support from healthcare professionals/ carers).
- Liver disease with any of the following:
  - Decompensated liver disease.
  - Receiving post-transplant immunosuppression or on transplant waiting list.
  - Other significant conditions or other organ involvement (renal, haematology, cardiac, GI, respiratory, diabetes mellitus).
  - Active or frequently relapsing autoimmune liver disease where an increase in treatment is likely needed.

#### Renal

- Renal transplant especially if in the last 3 months.
- On a high level of immunosuppressive medication for active disease undergoing induction treatment: those who are currently receiving or completed treatment within 6 weeks of high dose steroids of 20 mg/day or above (or 30 mg/m<sup>2</sup> /day) AND cyclophosphamide or rituximab or other immunosuppressants.
- Have renal disease and satisfy any of the following:
  - On haemodialysis
  - On 2 different immunosuppressants
  - Have active or frequently relapsing nephrotic syndrome

#### Respiratory

- Have significant impairment in ability to cough and to clear airway secretions: including children with severe neurological diseases such as severe cerebral palsy, neuromuscular disabilities, severe motor impairment and severe metabolic disease.
- Require a cough assist device to help with clearance of airway secretions.
- Life-dependent on long term ventilation, both invasive (via tracheostomy) and non-invasive (CPAP and BiPAP).

- Severe lung disease requiring continuous or overnight supplementary home oxygen and/or intermittent non-invasive ventilation.
- Children with:
  - Cystic fibrosis and Primary ciliary dyskinesia.
  - Severe bronchiectasis.
  - Severe restrictive lung disease such as interstitial lung disease or obliterative bronchiolitis.
  - Severe asthma: children treated with biological agents or maintenance oral steroids.
  - Children with repaired congenital thoracic abnormalities such as congenital diaphragmatic hernia / trachea-oesophageal fistula only if significant airway or lung problem.

#### Rheumatology / Paediatric ophthalmology

- On cyclophosphamide and/or high dose steroids, defined as  $\geq 0.5\text{mg/kg/day}$ , for 4 or more weeks, within the last 4 weeks.
- Have unstable or flaring rheumatological disease.