FIELD GUIDANCE – Revised July 20, 2021 (First issued November 30, 2020)

RE: ORR FIELD GUIDANCE # 6, COVID-19 INTAKE PROCEDURES FOR UNACCOMPANIED CHILDREN NEWLY ADMITTED INTO ORR CUSTODY

This document replaces the COVID-19 intake procedures guidance previously issued by ORR on March 23, 2021. This document is for licensed ORR care provider programs and influx care facilities.

Office of Refugee Resettlement (ORR) care providers are required to adhere to these provisions regarding COVID-19 quarantine, medical isolation, and testing procedures for unaccompanied children (UC) initially placed (newly admitted) into ORR custody. All other pre-existing ORR COVID-19 guidelines remain in effect. UC who test positive for COVID-19 must continue to be reported to ORR/Division of Health for Unaccompanied Children (DHUC) and to state and local public health authorities, as required.

This field guidance is based on current Centers for Disease Control and Prevention’s (CDC) guidance and recommendations and adapted for the UC Program.¹

In accordance with ORR Policy Guide, section 3.4.6, UC held in medical isolation or quarantine should continue receiving tailored services when feasible. These services include access to medical, urgent dental, mental health, legal, and educational services. In addition, care providers should ensure that medically isolated or quarantined children engage in social interaction with staff and are able to correspond with approved contacts via telephone, video conferencing, and mail, per ORR policy. The provision of these services may involve remote interaction and the use of personal protective equipment (PPE) to protect staff, and mask use by children and staff to help prevent the spread of COVID-19 at the program. ORR care providers must continue to supervise children and youth in their facilities, including children and youth in quarantine or medical isolation, in accordance with State licensing requirements and ORR Policy Guide, section 4.4.1.

Key revisions were made on July 20, 2021 to reflect the following:
- Updated language on cohorting quarantined children.

¹This guidance is dependent on the epidemiology of COVID-19 among children in ORR care. ORR will continually review COVID-19 trends among children in ORR care to determine whether and when these procedures should be modified or discontinued.
UC INTAKE PROCEDURES – COVID-19

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DEFINITIONS OF COMMONLY USED TERMS

Quarantine and Medical Isolation Terms

• **Cohorting** – In this guidance, cohorting refers to the practice of isolating multiple children with confirmed COVID-19 together, or quarantining potentially exposed, asymptomatic children together as a group (due to a limited number of individual rooms). Asymptomatic, exposed children cannot be cohorted with confirmed cases of COVID-19 or suspected cases of COVID-19 (i.e., children who show symptoms of COVID-19 but either have not been tested or are awaiting test results).

• **Medical isolation** – Medical isolation refers to separating someone with confirmed or suspected COVID-19 infection to prevent contact with others and reduce the risk of transmission. Medical isolation ends when the individual meets pre-established criteria (consistent with CDC guidance) for release from isolation, in consultation with healthcare providers and public health officials.

• **Quarantine** – Quarantine refers to the practice of separating individuals who have had close contact with someone with confirmed COVID-19 to determine whether they develop symptoms or test positive for the disease. Quarantine reduces the risk of transmission if an individual is later found to have COVID-19.

• **Routine intake quarantine**: Routine intake quarantine refers to the practice of separately housing newly referred UC before integrating them into general housing. This type of quarantine is used proactively for new intakes, to prevent introduction of the virus that causes COVID-19 (SARS-CoV-2), by incoming UC whose exposure status is unknown.

Test Terms

• **Molecular test** – Tests for current infection with the virus that causes COVID-19. These tests detect viral ribonucleic acid (RNA). Nucleic acid amplification tests (NAAT), such as real-time reverse transcription polymerase chain reaction (RT-PCR), are examples of molecular tests.
• **Antigen test** – Tests for current infection with the virus that causes COVID-19. These tests detect viral antigens.
• **Antibody test** – Tests for past infection with the virus that causes COVID-19. Antibody tests do NOT test for current infection or indicate whether someone is immune to the virus that causes COVID-19.
• **Rapid, point-of-care tests** – Tests that can be processed at the point of care location where the sample is collected, with results available in about 15 minutes. These may be molecular (NAAT) or antigen tests.


### LENGTH OF MEDICAL ISOLATION FOR COVID-19

Care providers should refer to CDC guidance on “Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings” for current and complete criteria for discontinuing medical isolation for COVID-19. As of February 18, 2021, persons with COVID-19 who have symptoms can discontinue isolation when at least 10 days have passed since symptom onset and at least 24 hours have passed since the resolution of fever without the use of fever-reducing medications and other symptoms have improved. For persons who never develop symptoms, isolation can be discontinued 10 days after the date of their first positive viral test for COVID-19 infection. Patients with severe illness or who are severely immunocompromised may require medical isolation for up to 20 days after symptom onset or date of first positive viral test.

### LENGTH OF QUARANTINE FOR COVID-19

As of March 13, 2021, CDC and ORR advise that all ORR care providers implement a 7-day quarantine and additional COVID-19 mitigation strategies. Care providers should refer to the CDC-ORR “COVID-19: Interim Guidance for Shortening Quarantine Duration and Increasing Testing for Office of Refugee Resettlement Facilities” (or the most recent version of the guidance, if updates have been issued). These recommendations should be applied throughout the guidance below.

References to a 10- or 14-day quarantine period are included in this document so that new guidance does not need to be issued should the recommended duration of quarantine be amended in the future or in response to changes in the epidemiology of COVID-19 among children in ORR care.

### COVID-19 INTAKE PROCEDURES

COVID-19 intake procedures for UC newly admitted into ORR custody are outlined in Scenarios 1-4 below (see also “COVID-19 Intake Procedures – Quick Reference” section).

**Scenario 1:** Asymptomatic children with no known COVID-19 exposure and who tested negative or were not tested prior to entering ORR care (i.e., routine intake quarantine)

ORR requires:

a. Quarantine for current recommended duration (e.g., 7, 10, or 14 days) from the date of admission to ORR custody. Care providers may need to cohort children in groups in order to
manage facility bed space. See “Instructions for Cohorting Quarantined or Medically Isolated Children” section below.
b. Testing upon admission or during the IME with two entry tests: a rapid, point-of-care test AND a lab-based, molecular test for COVID-19 (“entry tests”). The rapid, point-of-care test should be performed as soon after admission as possible, and the lab-based, molecular test should be performed at the same time or within 48 hours of the point-of-care test. If a child tests positive on either entry test, follow steps in Scenario 4.
c. Monitoring for symptoms\(^2\) of COVID-19 for no less than 14 days, regardless of quarantine length. If a child develops symptoms, follow steps in Scenario 3.
d. Testing within 48 hours before the end of quarantine, if a child has remained asymptomatic (“exit test”). A lab-based, molecular test is strongly preferred for the exit test if results will return by the end of quarantine. Otherwise, a rapid, point-of-care test can be used. If a child tests positive on the exit test, follow steps in Scenario 4.
e. Confirmed negative exit test results before release from routine intake quarantine to the general program population, or before transfer to another program.
f. Release the morning after completion of quarantine (e.g., morning of day 8, 11, 15, or whenever all exit tests of a cohort are confirmed negative). Discharge of children from ORR care prior to the end of intakes quarantine is authorized for children with no known COVID-19 exposures who meet all of the following conditions: 1) they have remained asymptomatic throughout their stay; 2) their entry COVID-19 test was negative; 3) they have met all other ORR medical requirements for unification with their sponsor; 4) they are unified directly from quarantine and do not enter the general program population, and; 5) the sponsor commits to following ORR COVID-19 discharge procedures, including a 14-day quarantine following a child’s physical discharge from ORR care. Sponsors should refer to their local health jurisdiction’s COVID-19 guidance to determine if a shortened quarantine can be used post-unification.
g. Performance of additional testing, on a case-by-case basis, as recommended by the local health department, the program’s designated healthcare provider, or DHUC.

Scenario 2: Asymptomatic children known to be exposed to a confirmed COVID-19 case within the last 14 days and who tested negative or were not tested prior to entering ORR care

ORR Requires:
a. Quarantine for current recommended duration (e.g., 7, 10, or 14 days) from the date of admission to ORR custody. Care providers may need to cohort children with the same exposure event in groups to manage facility bed space. See “Instructions for Cohorting Quarantined or Medically Isolated Children” section below.
b. Testing upon admission or during the IME with two entry tests: a rapid, point-of-care test AND a lab-based, molecular test for COVID-19 (“entry tests”). The rapid, point-of-care test should be performed as soon after admission as possible, and the lab-based, molecular test should be performed at the same time or within 48 hours of the point-of-care test. If a child tests positive on either entry test, follow steps in Scenario 4.

\(^{2}\) The most common symptoms of COVID-19 in children are fever and cough, but children may have any of these signs or symptoms of COVID-19: fever or chills; cough; nasal congestion or runny nose; new loss of taste or smell; sore throat; shortness of breath or difficulty breathing; diarrhea; nausea or vomiting; stomachache; tiredness; headache; muscle or body aches; poor appetite or poor feeding, especially in babies under 1 year old.
c. Monitoring for symptoms of COVID-19 for no less than 14 days, regardless of quarantine length. If a child develops symptoms, follow steps in Scenario 3. Testing within 48 hours before the end of quarantine, if a child has remained asymptomatic (“exit test”). A lab-based, molecular test is strongly preferred for the exit test IF results will return by the end of quarantine. Otherwise, a rapid, point-of-care test can be used. If a child tests positive on the exit test, follow steps in Scenario 4.

d. Confirmed negative exit test results before release from quarantine to the general program population, transfer to another program, or discharge from ORR care.

e. Release the morning after completion of quarantine (e.g., morning of day 8, 11, or 15). If a child with a known exposure to COVID-19 will turn 18 years of age and “age out” of ORR custody prior to completing quarantine, or if there are time-sensitive considerations around a child’s unification, contact DHUC for case-specific guidance.

f. Performance of additional testing, on a case-by-case basis, as recommended by the local health department, care provider’s healthcare provider, or DHUC.

Scenario 3: Symptomatic children with suspected COVID-19 who tested negative or were not tested prior to entering ORR care

For children who have COVID-19 symptoms identified prior to entering ORR care, on arrival, or who develop COVID-19 symptoms during the quarantine period, ORR requires:

a. Medical isolation in a private room, ideally with a private or dedicated bathroom.

b. Testing with either a lab-based, molecular test or a point-of-care test for COVID-19 to help confirm or rule out the diagnosis. If a point-of-care test is negative, it must be confirmed with a lab-based, molecular test within 48 hours. Additional testing for other diseases, such as influenza, may be recommended by the healthcare provider evaluating the child.

i. If any COVID-19 test is positive, the child must be medically isolated and monitored for new or worsening symptoms until they have met the CDC time-and-symptom-based criteria for discontinuation of isolation. Once confirmed, children may be moved into a cohort with other confirmed COVID-19 cases. See “Instructions for Cohorting Quarantined or Medically Isolated Children” section below.

ii. If all COVID-19 tests are negative, the child:

   • Must continue to be medically isolated in a private room and monitored while their medical workup proceeds. They cannot be cohorted with any other individuals, as they might have some other communicable disease such as influenza.

   • May be moved to quarantine and cohorted once other contagious illnesses have resolved or been ruled out. See “Instructions for Cohorting Quarantined or Medically Isolated Children” section below. The child should remain in quarantine for the current recommended duration (e.g., 7, 10, or 14 days) with continued symptom monitoring for no less than 14 days from the date admitted.

   • Must be tested within 48 hours before the end of quarantine (exit test). A lab-based, molecular test is preferred for the exit test IF results will return by the end of quarantine. Otherwise, a rapid, point-of-care test can be used.
Scenario 4: Children with COVID-19 diagnosed with a point-of-care test or lab-based, molecular test

For children who have been diagnosed with COVID-19 prior to entering ORR custody or at any point during the intake quarantine period, ORR requires:

a. Medical isolation, ideally with a private or dedicated bathroom, until they have met the CDC time-and-symptom-based criteria for discontinuation of isolation. Children with confirmed COVID-19 can be isolated together as a cohort. See “Instructions for Cohorting Quarantined or Medically Isolated Children” section below.

b. Retesting for COVID-19 upon admission to the program if there is no documentation of the COVID-19 test that was performed outside of ORR custody.
   i. If the child is symptomatic, they may be tested with either a lab-based, molecular test or a point-of-care test. If a point-of-care test result is negative, it must be confirmed with a lab-based, molecular test within 48 hours.
   ii. If the child does not have symptoms, they should be tested using both a point-of-care test AND a lab-based, molecular test for COVID-19. The rapid, point-of-care test should be performed as soon after admission as possible, and the lab-based, molecular test should be performed at the same time or within 48 hours of the point-of-care test.

c. Monitoring for development of new or worsening symptoms throughout the medical isolation period. Children should receive medical services in accordance with ORR Policy Guide, section 3.4.

INITIAL MEDICAL EXAM AND VACCINATION FOR QUARANTINED OR MEDICALLY ISOLATED CHILDREN

1. The IME should still be initiated within 2 business days of a child’s arrival to the program, regardless of whether the child is quarantined for exposure or medically isolated for illness. The IME is not considered a routine medical exam that can be delayed, as children newly entering ORR care might not have ever seen a healthcare provider, might have undiagnosed urgent medical needs, or might need rapid vaccination for post-exposure prophylaxis. Every effort should be made to complete all IME components in this timeframe if possible. However, access to some community healthcare resources might be disrupted during the COVID-19 response, resulting in delays of certain IME requirements (e.g., chest x-rays), and the IME TAR approval period has been temporarily extended because of this.

2. Children who are asymptomatic and quarantined for possible exposure to COVID-19 should receive IME vaccinations on time, including influenza vaccine when seasonally available.

3. Children who are confirmed cases of COVID-19 and who are asymptomatic should still receive IME vaccinations on time, including influenza vaccine when seasonally available.

4. Children who are confirmed cases of COVID-19 and who are symptomatic should have their vaccinations delayed until they have met the CDC time-and-symptom-based criteria for discontinuation of isolation.

5. Children who have influenza-like illness (fever and cough or sore throat) should also be tested for influenza at the IME, per existing IME guidelines.
TREATMENT AUTHORIZATION REQUESTS

1. A TAR is NOT required for COVID-19 molecular and antigen testing performed within 14 days from a child’s date of admission to ORR care. The healthcare provider can bill tests completed during this period using the IME authorization number.

2. A TAR is NOT required for point-of-care testing that is performed on site at the program, AND administered by program staff using point-of-care tests purchased by the program or ORR.

3. A TAR IS required for all COVID-19 molecular and antigen tests performed more than 14 days after a child’s admission to ORR care, excluding point-of-care tests performed on site as described in #2.

4. A TAR for COVID-19 antibody testing will NOT be authorized, except when ordered by the healthcare provider to help support a diagnosis for patients presenting with late complications of COVID-19 illness, such as multimodal inflammatory syndrome in children.

5. A TAR will NOT be authorized for repeat COVID-19 testing for children who tested positive in ORR care and recovered from COVID-19 within the past 90 days, except when ordered by a healthcare provider to evaluate a child with new symptoms for SARS-CoV-2 reinfection.

INSTRUCTIONS FOR COHORTING QUARANTINED OR MEDICALLY ISOLATED CHILDREN

Cohorting quarantined children who have not tested positive

1. Asymptomatic children belonging to the same cohort event can be cohorted together. A cohort event could be considered either of the following:
   a. Admit cohort: a group of newly admitted children with no known exposures that arrived to a care provider facility within a 48-hour period. Children with no known exposures should not be cohorted with children with a known exposure.
   b. Exposure cohort: a group of children all exposed to the same case on the same day. Children with different known exposures should not be cohorted together.

2. For admit cohorts, the 48-hour period begins at the earliest time of arrival among the children in the cohort.
   a. For example, two children are cohorted. One arrived at 10AM on July 1st, and the other arrived 9AM on July 3rd. A third child who arrived at 11AM on July 3rd cannot be added to the cohort, because it is 49 hours since the earliest admission time.

3. For admit cohorts, the 7-day quarantine period starts from the calendar day that is the latest admission date among children in a 48-hour arrival cohort.
   a. For example, two children are cohorted. One arrived at 10AM on July 1st, and the other arrived at 9AM on July 3rd. The 7-day quarantine period starts from the second child’s arrival date (July 3rd), because it is the latest date.

4. For admit cohorts, the 48-hour period means that some children may remain in intake quarantine for up to 9 days.
   a. For example, two children are cohorted. One arrived at 10AM on July 1st, and the other arrived at 9AM on July 3rd. The 7-day quarantine starts from the second child’s arrival date (July 3rd). Children in this cohort may be released from intakes quarantine the morning of July 11th if all COVID-19 clearance criteria have been met.
5. Children who are cohorted must wear masks as much as safely possible.\(^3\) Masks are most essential in times when physical distancing is difficult, or when using shared facilities, such as bathrooms. See “Required Source Control and PPE for Children and Staff” section below.

6. For cohorting quarantined children, there must be enough space in a room to maintain physical distancing between children in all directions. This means that all beds in an enclosed room might not be able to be filled when children are cohorted in it. When bed capacity allows for flexibility, children should be housed according to the following hierarchy:
   a. Separately, in single rooms with doors that close.\(^4\)
   b. Separately, in single rooms without doors that close.
   c. As a cohort, in a well-ventilated room with a door that closes and enough space to maintain physical distancing between each child in all directions. Bunks can be arranged so that children sleep head to foot to increase the distance between their faces.
   d. As a cohort, in a well-ventilated room without a door that closes and enough space to maintain physical distancing between each child in all directions. Bunks can be arranged so that children sleep head to foot to increase the distance between their faces.

7. If quarantined children from the same cohort event are initially placed in individual rooms, they may be cohorted later in their quarantine period to manage bed space (so long as they have no new exposures and remain asymptomatic). For example, three children all admitted within 48 hours of each other are in three separate rooms but are then moved to one single room in order to open more bed space at the program.

8. Newly admitted children with or without a known COVID-19 exposure who are at increased risk of severe disease (as reported by CBP or identified after entering ORR care), who might have a different communicable disease (e.g., varicella), or who might have been exposed to a different communicable disease should be assigned to their own private rooms and not cohorted.

9. Symptoms of all cohorted children should be monitored closely. Children who develop symptoms of COVID-19 or who test positive for COVID-19 during the quarantine period must immediately be removed from the cohort group, medically isolated, and medically evaluated. Children with confirmed COVID-19 can be moved into medical isolation with other confirmed COVID-19 cases as outlined in the section below.

10. If a child in a cohort tests positive for COVID-19, ORR considers the other children in the cohort to have been exposed to the virus. As a result, the quarantine clock restarts for these children when the child who tested positive is removed from the cohort. For this reason, the number of exposed children cohorted together should be as few as possible to prevent excessive quarantine durations.

11. Exit test results (see COVID-19 Intake Procedures, items 1d and 2d) must be received and be negative for all children in the cohort before the cohort is released from quarantine.

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\(^3\) Masks should not be worn by: children younger than 2 years old, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

\(^4\) Doors that do not have a window can be left open to allow for staff line-of-sight supervision of the child or cohort (see options b and d).
Cohorting medically isolated children with confirmed COVID-19

1. Children with documented, confirmed COVID-19 can be medically isolated together as a cohort. Cohorting of confirmed cases can help conserve PPE for staff and free up bed space. If space allows, children who have tested positive by only a point-of-care test should be cohorted separately from children who have tested positive via molecular test (e.g., PCR). If the point-of-care test is confirmed by a positive molecular test collected within 48 hours, the children can then be cohorted together. An individual child in the cohort can be released from medical isolation once that child has met the CDC time-and-symptom-based criteria for discontinuation of isolation. (The course of one child’s medical isolation does not affect the isolation release dates for other children in the cohort.)

2. Children with confirmed COVID-19 who also have another infectious disease (such as influenza) should be medically isolated in their own private rooms and not cohorted.
### REQUIRED SOURCE CONTROL AND PPE FOR CHILDREN AND STAFF *

<table>
<thead>
<tr>
<th>Type of Individual Wearing Source Control or PPE</th>
<th>N95 respirator**</th>
<th>Mask</th>
<th>Eye Protection</th>
<th>Gloves</th>
<th>Gown/Coveralls</th>
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</thead>
<tbody>
<tr>
<td><strong>Unaccompanied Children</strong></td>
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<td>Children who have confirmed or suspected (i.e., showing symptoms) COVID-19</td>
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<td>Asymptomatic children in quarantine</td>
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<td>Asymptomatic children who have been cleared to be in the general shelter population</td>
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<td><strong>Staff</strong></td>
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<tr>
<td>Staff not having direct contact with children</td>
<td>X (All staff should wear a mask as much as safely possible, unless they are the only person occupying a work area)***</td>
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<tr>
<td>Staff having direct contact with asymptomatic children under quarantine for possible exposure to COVID-19 (including staff performing temperature checks or providing medical care)</td>
<td>X***</td>
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<tr>
<td>Staff having direct contact with (including transport) or offering medical care to children with confirmed or suspected COVID-19</td>
<td>X</td>
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* Adapted from CDC guidelines and recommendations.

** A respirator (e.g., N95) without an exhalation valve should be worn for situations requiring both source control and respiratory protection from SARS-CoV-2 and other workplace hazards.

*** See CDC recommendations on how to improve mask fit and filtration. For care provider staff, this may include wearing two masks, i.e., a medical procedure mask underneath a cloth mask. See also special considerations for mask use. Masks should not be worn by: children younger than 2 years old, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
COVID-19 Intake Procedures – Quick Reference

Refer to ORR Field Guidance #6 for additional detail
Version Date: 07/20/2021

Was the newly admitted child diagnosed with COVID-19 while in DHS custody?

**NO OR UNKNOWN**

Does the child have symptoms of COVID-19 or of another contagious illness?

**NO**

Is the child known to have been exposed to a confirmed COVID-19 case in the last 14 days?

**NO**

**YES**

**YES**

**SCENARIO 1:** No Symptoms + No Known Exposure

1. Quarantine and monitor*
2. Test on admission or at IME (entry tests)
3. If child develops symptoms during quarantine, follow steps in Scenario 3
4. If child tests positive during quarantine, follow steps in Scenario 4
5. Child may be cohorted with other asymptomatic, unexposed children who were admitted within a 48-hour period
6. Test within 48 hours before end of quarantine (exit test)

**COVID-19 CLEARANCE CRITERIA:**

- Release after completion of quarantine if:
  a) Child remains asymptomatic AND
  b) Child had no exposures in quarantine AND
  c) Entry & exit tests were negative AND
  d) If cohorted, exit tests for entire cohort were negative

**SCENARIO 2:** No Symptoms + Known Exposure

1. Quarantine and monitor*
2. Test on admission or at IME (entry tests)
3. If child develops symptoms during quarantine, follow steps in Scenario 3
4. If child tests positive during quarantine, follow steps in Scenario 4
5. Child may be cohorted with other asymptomatic children who were part of the same exposure event
6. Test within 48 hours before end of quarantine (exit test)

**COVID-19 CLEARANCE CRITERIA:**

- Release after completion of quarantine if:
  a) Child remains asymptomatic AND
  b) Child had no exposures in quarantine AND
  c) Entry & exit tests were negative AND
  d) If cohorted, exit tests for entire cohort were negative

**SCENARIO 3:** Suspected COVID-19

1. Medically isolate in a private room
2. Conduct COVID-19 testing and testing for other diseases, as recommended by PCP
3. If COVID-19 (+), follow steps in Scenario 4
4. If COVID-19 (-):
   a) Quarantine and monitor*
   b) Child may be cohorted with children from the same admit or exposure cohort once asymptomatic AND other contagious illnesses have been ruled out
   - Test within 48 hours before end of quarantine (exit test)

**COVID-19 CLEARANCE CRITERIA:**

- Release after completion of quarantine if:
  a) Child remains asymptomatic AND
  b) Child had no exposures in quarantine AND
  c) Entry & exit tests were negative AND
  d) If cohorted, exit tests for entire cohort were negative

**COVID-19 CLEARANCE**

- COVID-19 RULED OUT
- COVID-19 CONFIRMED

**SCENARIO 4:** Confirmed COVID-19

1. Isolate and monitor for at least 10 days
2. Retest if there is no documentation of the original positive COVID-19 test result
3. Child may be cohorted with other children who have confirmed COVID-19 if:
   a) there is documentation of a positive COVID-19 test result, and
   b) the child does not have any other contagious illnesses

**COVID-19 CLEARANCE CRITERIA 1:**

- Release from medical isolation on Day 11 if:
  a) At least 24 hours have passed since the resolution of fever without the use of fever-reducing medications AND
  b) Other symptoms have improved

1. Medical isolation period  
   Day 0: Symptom onset (or specimen collection date if asymptomatic)  
   1  2  3  4  5  6  7  8  9  10  11  
   Day 11: Release from isolation if all criteria are met

2. Quarantine period*  
   Day 0: Date admitted to care provider program  
   1  2  3  4  5  6  7  8  9  10  11  
   Day 8: Release from quarantine if all criteria are met

* As of March 13, 2021 CDC and ORR advise that all ORR care providers implement a 7-day quarantine and additional COVID-19 mitigation strategies. Care providers should refer to the CDC-ORR “COVID-19: Interim Guidance for Shortening Quarantine Duration and Increasing Testing for Office of Refugee Resettlement Facilities” (or the most recent version of the guidance, if updates have been issued).