

# PANTHER PRESS

## KNIGHTSTOWN ELEMENTARY

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### DATES TO REMEMBER

**SEPT 10**  
Picture Day

**SEPT 12**  
Food Pantry

**SEPT 16-20**  
Book Fair

**SEPT 17**  
Grandparents' Night

**SEPT 20**  
Respect Convocation

**SEPT 23**  
Hat Day

**SEPT 24**  
Neon Day

**SEPT 25**  
Crazy Sock Day

**SEPT 26**  
Jersey Day

**SEPT 27**  
Red & Black Day



### Candy Donations

KES staff will have a float in the Homecoming parade again this year.

If you would like to donate a bag of candy, please send it to school with your child or drop it off in the office. Donations are greatly appreciated!

### Arrival & Dismissal

Arrival: 7:45-8:00 a.m.

Breakfast: 7:45 a.m.

Tardy Bell: 8:00 a.m.

Dismissal: 3:00 p.m.

### NWEA & Dyslexia

First & second grade's universal dyslexia screening results and beginning of the year NWEA scores for K-3 will go home next week. Please check your child's red folder for these reports. Students who fell below the determined benchmark on the universal dyslexia screener may participate in further screening. If you have any questions, please contact your child's teacher.

## School Picture Information

Picture Day is Tuesday, September 10th.

This year, your child's school pictures can be customized and are available online at [www.strawbridge.net](http://www.strawbridge.net).

On the website, you are able to do the following:

- Preview photos
- Personalize photos
- Order photos

The event code for KES is FM453840.

## Scholastic Book Fair

Students will shop in-person during their Library time the week of September 16th - 20th.

Cash, check and eWallet will be accepted for purchases. You can learn more about eWallet on our book fair webpage. See link below.

Cash and checks should be sent with your child in an envelope labeled with the student's name, grade, teacher, and amount enclosed.

<https://bookfairs.scholastic.com/bf/knightstownelemschool>

## Grandparents' Night

At KES, we love celebrating our grandparents! We are excited to welcome our students and their grandparents on Tuesday, September 17th from 4:30-6:30 p.m. for Grandparent's Night.

Grandparents will be able to visit their grandchild's classroom, enjoy a snack in the cafeteria, shop at the book fair, and take part in an optional photo op for \$3 per printed photo.

## PTO Fundraiser

KES PTO will be selling Otis Spunkmeyer cookies again this year along with some other goodies! Please be on the lookout for the flyer and order form in your child's folder. The sale will run from Friday, September 13 - Monday, September 30.

Money is due when orders are placed. Items should be available for pick-up in October. Please follow KES PTO on Facebook for more information and details.

## TRANSPORTATION CHANGES

Email Mrs. Wilson at [tiffany.wilson@cabeard.k12.in.us](mailto:tiffany.wilson@cabeard.k12.in.us) with any transportation changes

### Include in the email:

- Date for the change
- Child's first and last name
- Teacher
- Destination
- New bus number (if known)

Please send a note with your child on the day they are going to a different place. If possible, please do not call the office with changes.

**\*Changes to transportation must be received before 12:00 p.m.**

## ATTENDANCE

Attendance is critical to your child's success in school. All children are expected to be in school each day unless they are ill.

It is important that students are screened each morning for COVID-19 and other illness symptoms prior to arriving at school.

Students are allowed 20 absences per year. A letter will be sent home making you aware of absences.

If your child will be absent from school, call the KES office at 765-345-2151 or send an email to:

Mrs. Wilson at  
[tiffany.wilson@cabeard.k12.in.us](mailto:tiffany.wilson@cabeard.k12.in.us)

-OR-  
Mrs. Roland at  
[emily.roland@cabeard.k12.in.us](mailto:emily.roland@cabeard.k12.in.us)

## MEDICATION

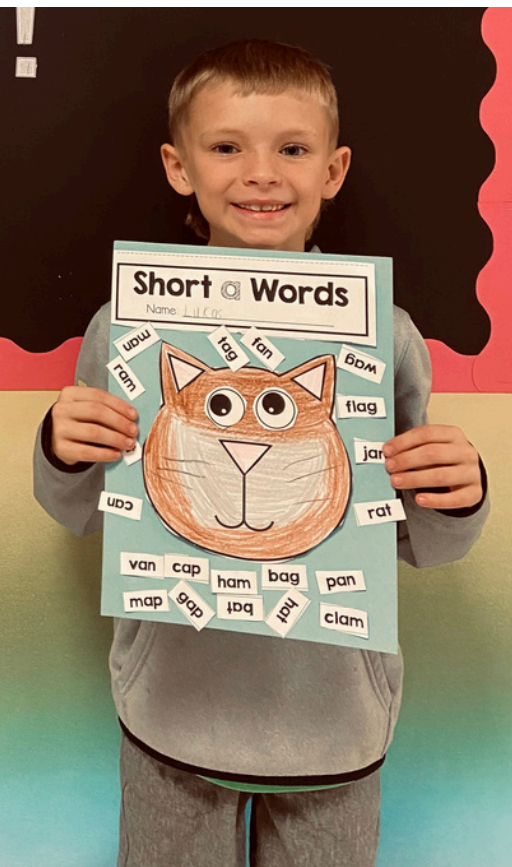
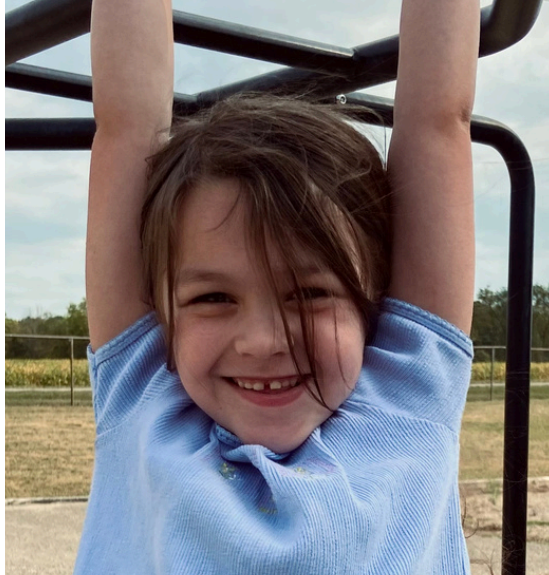
Parents or guardians are responsible for bringing any new, unopened medication to the nurse's office.

This includes cough drops.

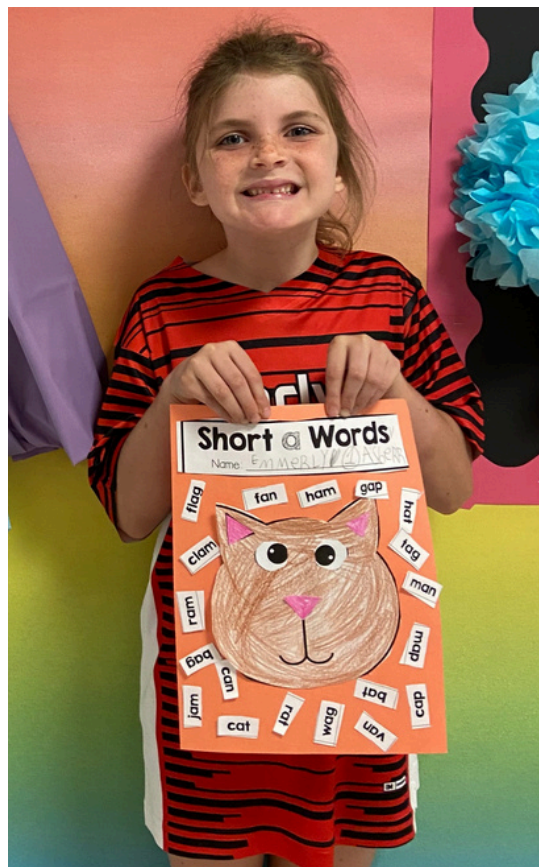
Parents or guardians and/or a doctor must fill out medical forms in order for medication to be dispensed.

Antibiotics given 3 times per day should be given at home: before school, after school, & at bedtime.





Mrs. VanBritson  
1ST GRADE







# WE'RE HIRING

## Substitute Teachers and Paraprofessionals

ESS has exciting substitute opportunities every day at schools near you. Support your community while working for a company that was named one of America's Best Large Employers by Forbes!

### We Offer Amazing Employee Perks

- Flexible Schedule
- Health Benefits & 401(k)
- Ongoing Training Opportunities
- Bonus Programs
- 24/7 Access to Job Openings



Apply Today! Visit us at [willSub.com](http://willSub.com)  
or call **877.855.7264** to learn more.

**KES needs your help!**  
We are searching for more substitute teachers.  
If you are interested in subbing in our school,  
**please apply to WillSub today.**

Did you know that you can only accept  
grade levels **YOU** feel comfortable with?

Did you know that you can also only  
accept teachers **YOU** want to sub for?

**As the sub, you have complete control!**  
Just indicate your preferences on your application.

Please call **877.855.7264** to find out more info!





# **SOCCER SKILLS CAMP**



**DATE** **SEPTEMBER**  
**11**

**Boys & Girls  
Kindergarten -  
3rd grade**

**At KHS 7-8:30 under the lights**

**Kids will get a T-shirt for  
attending**

**Cost** **\$25**

**Forms need to be returned by August 30th**

Cash or Checks made payable to Dusty Magee





## Back to School Vaccinations

### **Does your child still need their vaccinations for school?**

A great opportunity is now available for all Charles A. Beard Memorial School Corporation families. The Henry County Health Department will come to each school building and conduct immunizations that are state required and recommended during the school day. This onsite opportunity will be the most convenient option for our busy families.

Simply complete the Immunization Registration and Consent Form and return it to your child's school. You may also call the Henry County Health Department directly to sign up and give verbal consent for your student to participate at 765-521-7059.

Please note that there will not be a specified date and time for this program. Once the Health Department receives consent forms they will come to each building and provide on site immunizations. We will post dates on the Corporation Health Services page when dates are known.

If you complete the consent form, you do not have to be present. If you wish to be present for your student's vaccinations, please tell the Henry County Health Department that at the time of your consent enrollment.

Simply complete the Consent form or call the Health Department to enroll in this opportunity.

Sincerely,

Tracie Smith, MSN, RN  
Charles A. Beard Memorial School Corporation  
Director of Health Services



## Indiana Department of Health – Registration and Consent Form

Complete the following for the person who is being vaccinated:

Patient Name: FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_  
 Phone: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender (assigned at birth): ☐ F ☐ M  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Parent/Guardian Full Name: \_\_\_\_\_ Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino  
 Race: (Check all that apply)  
☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unspecified ☐ White ☐ Declined

**Insurance Status (Check box)**

☐ NO INSURANCE

☐ MEDICAID

Company: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

☐ PRIVATE or COMMERCIAL INSURANCE (NOT MEDICAID) *Attach a copy of card to form if possible*

Company: \_\_\_\_\_ Policy/Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder Relationship to Patient: \_\_\_\_\_

**Health Screening Questions for the Person Getting Vaccinated:**

1. Is the person sick today? If yes, what are their symptoms?	<input type="checkbox"/> No <input type="checkbox"/> Yes	7. Has the person ever had a seizure, brain, or other nervous system problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Any allergies to medication, foods, a vaccine component, or latex? Please list allergies:	<input type="checkbox"/> No <input type="checkbox"/> Yes	8. Does the person take cortisone, prednisone, other steroids or anticancer drugs, or have had x-ray treatments for cancer?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Has the person ever had a serious reaction to a vaccine in the past? If yes, please explain:	<input type="checkbox"/> No <input type="checkbox"/> Yes	9. For women- is the person pregnant or is there a chance they could become pregnant during the next month?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Has the person ever had Guillian-Barre Syndrome (GBS)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	10. Does the person smoke or vape?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Does the person have a long-term health problem with heart, lung or kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorders (e.g. sickle cell)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	11. During the past year, has the person received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Does the person have cancer, leukemia, AIDS or any other immune system concerns?	<input type="checkbox"/> No <input type="checkbox"/> Yes	12. Has the person received any vaccinations in the past 4 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes

**Consent Statement (continued on other side)**

By signing below, I consent to the use and disclosure of my or my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to Indiana Department of Health (IDOH) and VaxCare for the services rendered.

**Consent for Use of Protected Health Information & Claims Assignment:** I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to VaxCare associated with the services contemplated herein.

Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me or my dependent by an IDOH representative. I relieve VaxCare, the VaxCare partner (IDOH), the administering person and personnel of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual basis through arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association. Neither I nor IDOH or VaxCare shall be entitled to join or consolidate claims in arbitration by or against other individuals or entities or arbitrate any claims as a representative member of a class or in private attorney general capacity. In the case of the occupational exposure, IDOH has patient's permission for blood testing for patient and employee safety alike.

I have read or have had explained to me the information from the Vaccine Information Statement(s) and understand the risks (including adverse reactions) and benefits of the vaccine(s). If consenting for another, I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine(s) administration.

**I consent to myself/my child being vaccinated with all recommended vaccinations that are due at this time. If I want to refuse any specific vaccine(s), then I will call 317-519-2079 or email: [mlayman@isdh.in.gov](mailto:mlayman@isdh.in.gov)**

Vaccines that may be administered based on you/your child's vaccination record: DTaP/Tdap, Hepatitis A, Hepatitis B, Haemophilus influenzae type b (HIB), Human Papilloma Virus (HPV), Influenza, MMR, Meningitis, Polio, Pneumonia, Rotavirus, Varicella, and Covid-19.

Signature: X \_\_\_\_\_

Date: \_\_\_\_\_

*Parent/Guardian signature required if under 18 years old*



**Charles A Beard Memorial School Corporation**  
**Fever and Contagious Illness Protocol**

**Fever:** A clinical fever is 100.4 degrees. Any student that has a temperature of 100.4 degrees or greater must remain home from school or be sent home from school. They must remain home until the fever has resolved, without fever reducing medication, for a full 24 hours before they can return to school.

**Diarrhea:** If a student has diarrhea, they must remain home from school or be sent home from school. They shouldn't return to school until they are diarrhea free for 24 hours, without medication to prevent diarrhea.

**Vomiting:** If a student vomits, they must remain home or be sent home from school. They should remain home for a full 24 hours from the last vomiting episode.

**Rashes:** Students should remain home or be sent home for rashes. A doctor note will be requested for students who have a rash. After treatment with prescribed medication, the student can return 24 hours later. The exception is if it is a poison ivy rash.

**Parasitic Infections:** Students must be treated according to their doctor's recommendation and have taken appropriate medication for 24 hours before they can return to school.

**COVID:** Students and families must follow their doctor's recommendations. Most health care providers state to remain home and isolate for a full 5 days or longer, until symptoms are resolving. Students must be fever free without fever reducing medication for a full 24 hours before returning. The student should also feel well enough to return to class. Masking is recommended for days 6-10.

**Conjunctivitis (Pink Eye):** Students must remain home for 24 hours after prescription treatment.

**Influenza:** Students should be fever free for 24 hours without fever reducing medication and until symptoms are resolving.