VOL. 5, NO. 4 AUG 30, 2024

PANTHER PRESS

KNIGHTSTOWN ELEMENTARY

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DATES TO REMEMBER

AUG 26-SEPT 6
1st & 2nd Grade
Universal Dyslexia
Screener Window

SEPT 2
Labor Day
No School

SEPT 3
Teacher PD Day
No School

SEPT 4
1st Grade
Vision Screening

SEPT 10
Picture Day

SEPT 12
Food Pantry

SEPT 16-20
Book Fair

SEPT 17
Grandparents' Night

No School

We will not have school on Mon., Sept. 2 for Labor Day. There will also be no school on Tues., Sept. 3 due to corporation-wide professional development for staff. NO assignments will be posted to Google Classroom for either day.

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.

Food Pantry

KES has partnered with Second Harvest Food Bank again this year to bring our families a monthly food pantry. This event is held on the second Thursday of each month and is FREE to ALL CAB families. There are no forms to fill out and proof of identification and income are not needed to participate.

SECOND HARVEST food bank

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.
On the website, you are able to do the following:
Preview photos
Personalize photos
Order photos
The event code for KES is FM453840.

Dismissal Information

Upon entering the south entrance of our school's parking lot, drive around the perimeter of the lot, following the yellow lines. You will stop at the sign and wait for a staff member to direct you forward. For staff and student safety, do NOT start lining up prior to 2:15 p.m. Waiting cars should remain parked until after buses have cleared the parking lot. Waiting lines are two cars wide. End of the day office pick-ups are not permitted. No one should be going into the school to pick up students who are car riders.
Please be extra cautious and practice courteous driving anytime you are in our parking lot.

Clothing & Shoe Donations

Our clothing supply closet that we use for students who have accidents or spills throughout the day is running low. We are in need of all sizes of boys and girls gently used (no stains or holes) shorts and all sizes of shoes. Please no flip flops. We appreciate your donations!

Names, Please!

Please be sure your child's FIRST & LAST name are on all items he/she brings to school, including water bottles. We have acquired quite the collection of lost items already in our lost and found! If you're missing any items, please let your child's teacher know.

PTO

Our PTO helps sponsor many fun events during the school year, and we can't do them without the help of our amazing parents! We would love to have more members this school year. Upcoming Events:
Book Fair (9/16-20) & Grandparents' Night (9/17)
Please email Gayle Davis at
gayle.davis@cabeard.k12.in.us
if you are interested in helping PTO with events.

TRANSPORTATION CHANGES

Email Mrs. Wilson at
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.

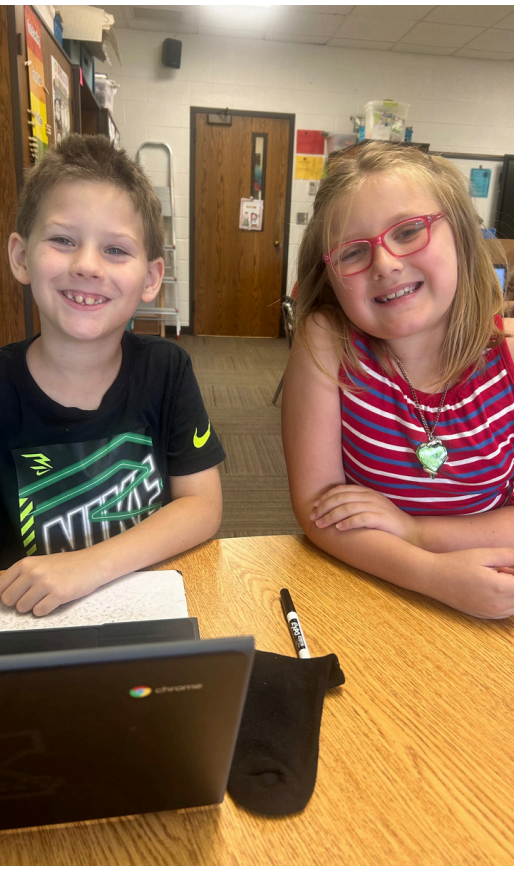
Students are allowed 20 absences per year. A letter will be sent home making you aware of absences.

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

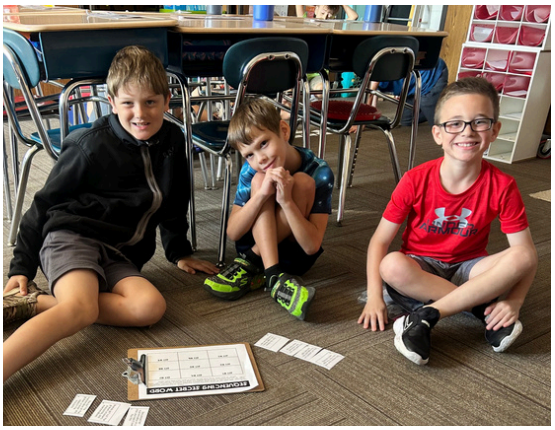
Mrs. Wilson at
tiffany.wilson@cabeard.k12.in.us
-OR-
Mrs. Roland at
emily.roland@cabeard.k12.in.us

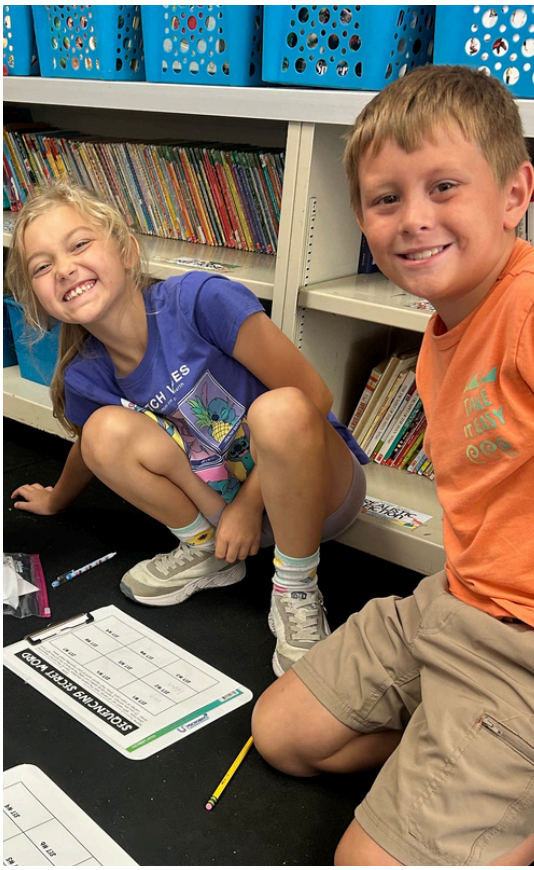
MEDICATION

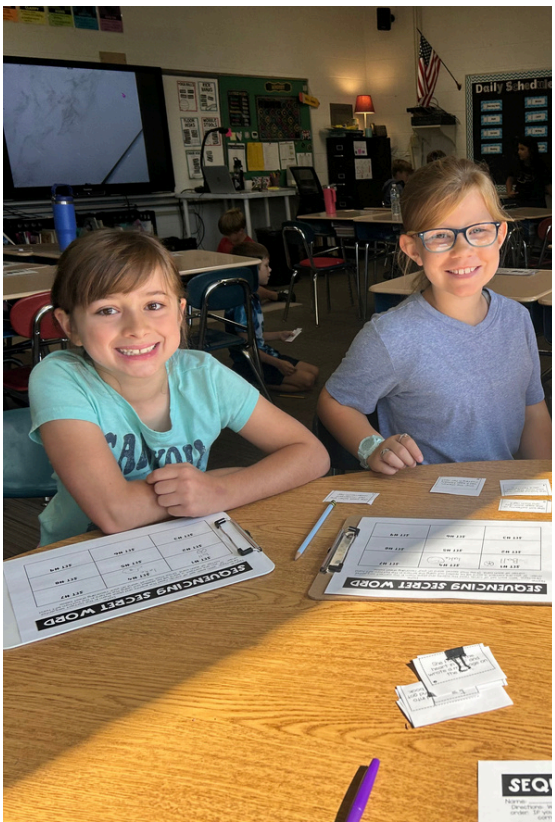
Parents or guardians are responsible for bringing any new, unopened medication to the nurse's office. This includes cough drops.
Parents or guardians and/or a doctor must fill out medical forms in order for medication to be dispensed.
Antibiotics given 3 times per day should be given at home: before school, after school, & at bedtime.



Mrs. James's 3RD GRADE







First Grade Vision Screening

TO: Parents of 1st Grade Students

WHAT: Indiana law requires **the Modified Clinical Technique Vision Screening (MCT)** in either Kindergarten or First Grade. It includes four major testing categories:
1. Visual Acuity, 2. Binocular Coordination, 3. Refractive Error, and 4. Ocular Health.

HOW: Seven visual screening tests will be administered by Dr. C.J. Shaneyfelt, a local optometrist, his office staff, and the school nurse at Knightstown Elementary School during your child's regular school day.

WHY: This screening is required by Indiana Law from the State Department of Education. Much of your child's learning is accomplished through vision. This screening is vital in identifying visual defects and problems that impair a child's learning ability. No form of vision screening is a substitute for a comprehensive eye examination administered by a licensed eye care professional; however, as an **"early warning system"**, a vision screening is useful in detecting conditions that require referral to an eye care professional.

WHEN:Wednesday, September 4, 2024

If you do not wish for your child to participate in this free screening, please send in a note to decline your child's participation.

Thank you!

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

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?	□ No □ Yes	7. Has the person ever had a seizure, brain, or other nervous system problem?	□ No □ Yes
2. Any allergies to medication, foods, a vaccine component, or latex? Please list allergies:	□ No □ Yes	8. Does the person take cortisone, prednisone, other steroids or anticancer drugs, or have had x-ray treatments for cancer?	□ No □ Yes
3. Has the person ever had a serious reaction to a vaccine in the past? If yes, please explain:	□ No □ Yes	9. For women- is the person pregnant or is there a chance they could become pregnant during the next month?	□ No □ Yes
4. Has the person ever had Guillian-Barre Syndrome (GBS)?	□ No □ Yes	10. Does the person smoke or vape?	□ No □ 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)?	□ No □ 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?	□ No □ Yes
6. Does the person have cancer, leukemia, AIDS or any other immune system concerns?	□ No □ Yes	12. Has the person received any vaccinations in the past 4 weeks?	□ No □ 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
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.