SAFE CHild Screening Tool: Grades 1 to 5

Children referred to educators or school nurses for assistance because of academic, behavioral, or physical challenges sometimes have histories of possible brain injuries. The SAFE CHild Screening tool provides information to help educators develop and implement appropriate accommodations and services.

Completing this form will not diagnose your child with a brain injury!
If you have concerns about your child, contact your physician or an educator.

Child's Name:	Child's date of birth:	Today's Date :
Your relationship to child:	Child's gender: □ Male □ Female	Child's grade: 1 2 3 4 5

Child's race: □ African American □ Caucasian □ Asian□ Hispanic □ Native American □ Other_____
Is your child currently receiving special education services? □ Yes □ No
If yes, what is your child's disability?

***S*ickness**	Has your child ever had a seizure, high fever (greater than 104 degrees), infection of the brain or spinal cord (e.g., meningitis or encephalitis), or other serious illness affecting the brain?	□ Yes □ No If yes, how many times? _____
***A*ccidents**	Has your child ever: been in a car accident? □ Yes □ No experienced a near drowning or suffocation? □ Yes □ No stopped breathing for one minute or longer? □ Yes □ No been exposed to a toxin (e.g., lead, carbon monoxide)? □ Yes □ No or sustained a blow to the head? □ Yes □ No	□ Yes □ No If yes, how many times? _____
***F*alls**	Has your child ever had a substantial fall resulting in a blow to the head (e.g., down stairs, from playground equipment, or when riding a bicycle/scooter/motor bike)?	□ Yes □ No If yes, how many times? _____
***E*mergency Room**	Has your child ever needed emergency medical attention because of disorientation, a loss of consciousness, or a blow to the head?	□ Yes □ No If yes, how many times? _____
	What is the total number of possible injuries for your child?	Total_____

***CH*ild Behaviors**

If you answered **YES** to any of the above questions, have you noticed any of the following behaviors in your child since the incident? Check all that apply:

□ Sensitivity to light or sound

□ Frequent headaches, nausea, or ringing ears

□ Coordination problems, clumsiness, or dizziness

□ Impulsive behaviors or outbursts of anger

□ Changes in vision

□ Changes in sleeping habits

□ Lack of energy or tiring easily

□ Other _____

□ Sadness, anxiety, or irritability

□ Difficulty with school work or loss of previously-mastered academic skills

□ Limited social interactions with friends or a change in personality

□ Loss of interest in previously-enjoyed activities

□ Problems with attention, concentration, organization, memory, multi-tasking, or starting or finishing tasks

Revised June 2013

Development of the ***SAFE CHild Screening Tool*** was supported in part by TBI Implementation Partnership Grant #H21MCO6758 from the Department of Health and Human Services (DHHS), Health Resources and Services Administration, Maternal and Child Health Bureau. The contents are the sole responsibility of the authors and do not necessarily represent the official views of DHHS. Authors include members of the Task Force on Children and Youth of the Nebraska Brain Injury Advisory Council. **This is in the public domain. Please duplicate and distribute widely.**