SAFE CHild Screening Tool: Birth to 3-year-olds

Young children are at high risk for sustaining brain injuries. The SAFE CHild Screening tool provides information to help professionals develop and implement appropriate accommodations or 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: ___________________________________ My child is receiving early intervention services through my school district. □ Yes □ No My child's disability is: __________________________.	Child's gender: □ Male □ Female

Child's race: □ African American □ Caucasian □ Asian □ Hispanic □ Native American □ Other______________

Sickness	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? ____________
Accidents	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? ____________
Falls	Has your child ever had a substantial fall resulting in a blow to the head (e.g., down stairs, off a changing table, from playground equipment, while climbing, or when riding a tricycle/scooter)?	□ Yes □ No If yes, how many times? ____________
Emergency Room	Has your child ever needed emergency medical attention because of a loss of consciousness or blow to the head?	□ Yes □ No If yes, how many times? ____________
	What is the total number of possible injuries for your child?	Total:
CHild 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: □ Decreased strength □ Decreased coordination □ Decreased sucking/swallowing □ Decreased ability to lift or hold head □ Decreased smiling/vocalizing □ Decreased language/communication □ Decreased tolerance to light □ Decreased appetite □ Frequent rubbing of eyes/head □ Decreased ability to focus eyes □ Extreme irritability □ Unequal size of pupils □ Other ______________________________	

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