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

Young children are at high risk for sustaining brain injuries. The SAFE CHild Screening tool provides information to help educators 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.

<table>
<thead>
<tr>
<th>Child’s Name:</th>
<th>Child’s date of birth:</th>
<th>Today’s Date:</th>
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Your relationship to child: __________________________

Is your child currently receiving special education services? □ Yes □ No

My child’s disability is: _______________________________

Child’s gender: □ Male □ Female

Child’s race: □ African American □ Caucasian □ Asian □ Hispanic □ Native American □ Other

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## 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

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, from playground equipment, or when riding a tricycle/bicycle/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 your child’s total number of possible injuries? Total_________

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## 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
- □ Frequent headaches or nausea
- □ Frequent rubbing of eyes
- □ Sensitivity to light or sound
- □ Changes in activity level or tiring easily
- □ Loss of previously-mastered skills such as toileting or handling small objects
- □ Other ____________________________
- □ Coordination problems, clumsiness, loss of balance, or dizziness
- □ Extreme irritability or crankiness
- □ Decreased language/communication
- □ Changes in eating or sleeping habits
- □ Changes in play behaviors
- □ Changes in school performance

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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.