

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.

Child's Name:		Child's date of birth:	Today's Date:														
Your relationship to child: _____ Is your child currently receiving special education services? <input type="checkbox"/> Yes <input type="checkbox"/> No My child's disability is: _____.		Child's gender: <input type="checkbox"/> Male <input type="checkbox"/> Female															
Child's race: <input type="checkbox"/> African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____														
Accidents	Has your child ever: been in a car accident? <input type="checkbox"/> Yes <input type="checkbox"/> No experienced a near drowning or suffocation? <input type="checkbox"/> Yes <input type="checkbox"/> No stopped breathing for one minute or longer? <input type="checkbox"/> Yes <input type="checkbox"/> No been exposed to a toxin (e.g., lead, carbon monoxide)? <input type="checkbox"/> Yes <input type="checkbox"/> No or sustained a blow to the head? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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)?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____														
	What is your child's total number of possible injuries?		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: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Decreased strength</td> <td><input type="checkbox"/> Coordination problems, clumsiness, loss of balance, or dizziness</td> </tr> <tr> <td><input type="checkbox"/> Frequent headaches or nausea</td> <td><input type="checkbox"/> Extreme irritability or crankiness</td> </tr> <tr> <td><input type="checkbox"/> Frequent rubbing of eyes</td> <td><input type="checkbox"/> Decreased language/communication</td> </tr> <tr> <td><input type="checkbox"/> Sensitivity to light or sound</td> <td><input type="checkbox"/> Changes in eating or sleeping habits</td> </tr> <tr> <td><input type="checkbox"/> Changes in activity level or tiring easily</td> <td><input type="checkbox"/> Changes in play behaviors</td> </tr> <tr> <td><input type="checkbox"/> Loss of previously-mastered skills such as toileting or handling small objects</td> <td><input type="checkbox"/> Changes in school performance</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>			<input type="checkbox"/> Decreased strength	<input type="checkbox"/> Coordination problems, clumsiness, loss of balance, or dizziness	<input type="checkbox"/> Frequent headaches or nausea	<input type="checkbox"/> Extreme irritability or crankiness	<input type="checkbox"/> Frequent rubbing of eyes	<input type="checkbox"/> Decreased language/communication	<input type="checkbox"/> Sensitivity to light or sound	<input type="checkbox"/> Changes in eating or sleeping habits	<input type="checkbox"/> Changes in activity level or tiring easily	<input type="checkbox"/> Changes in play behaviors	<input type="checkbox"/> Loss of previously-mastered skills such as toileting or handling small objects	<input type="checkbox"/> Changes in school performance	<input type="checkbox"/> Other _____	
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