

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

Young children are at high risk for sustaining brain injuries. Data gathered using the SAFE CHild Screening Tool will provide information to help professionals develop and implement appropriate services.

Completing this form will not diagnose your child with a brain injury.

Consult your medical provider if you have brain injury concerns regarding your child.

Today's date:	Child's date of birth:														
Your relationship to child:	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	<p>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?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____</p>														
Accidents	<p>Has your child ever:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding: 2px 0 2px 20px;">been in a car accident?</td> <td style="text-align: right; padding: 2px 0 2px 20px;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px 0 2px 20px;">experienced a near drowning or suffocation?</td> <td style="text-align: right; padding: 2px 0 2px 20px;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px 0 2px 20px;">stopped breathing for one minute or longer?</td> <td style="text-align: right; padding: 2px 0 2px 20px;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px 0 2px 20px;">been exposed to a toxin (e.g., lead, carbon monoxide)?</td> <td style="text-align: right; padding: 2px 0 2px 20px;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 2px 0 2px 20px;">or sustained a blow to the head?</td> <td style="text-align: right; padding: 2px 0 2px 20px;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____</p>	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				
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Falls	<p>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)?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____</p>														
Emergency Room	<p>Has your child ever needed emergency medical attention because of a loss of consciousness or blow to the head?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____</p>														
CHild Behaviors	<p>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:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Decreased strength</td> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Decreased coordination</td> </tr> <tr> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Decreased sucking/swallowing</td> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Decreased ability to lift or hold head</td> </tr> <tr> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Decreased smiling/vocalizing</td> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Decreased language/communication</td> </tr> <tr> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Decreased tolerance to light</td> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Decreased appetite</td> </tr> <tr> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Frequent rubbing of eyes/head</td> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Decreased ability to focus eyes</td> </tr> <tr> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Extreme irritability</td> <td style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Unequal size of pupils</td> </tr> <tr> <td colspan="2" style="padding: 2px 0 2px 20px;"><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Decreased strength	<input type="checkbox"/> Decreased coordination	<input type="checkbox"/> Decreased sucking/swallowing	<input type="checkbox"/> Decreased ability to lift or hold head	<input type="checkbox"/> Decreased smiling/vocalizing	<input type="checkbox"/> Decreased language/communication	<input type="checkbox"/> Decreased tolerance to light	<input type="checkbox"/> Decreased appetite	<input type="checkbox"/> Frequent rubbing of eyes/head	<input type="checkbox"/> Decreased ability to focus eyes	<input type="checkbox"/> Extreme irritability	<input type="checkbox"/> Unequal size of pupils	<input type="checkbox"/> Other _____	
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May 2011

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