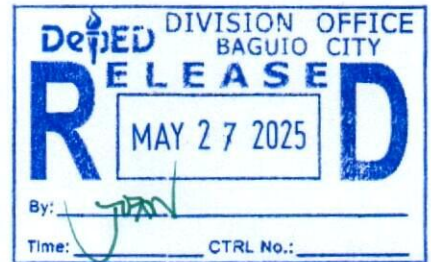




Republic of the Philippines  
**Department of Education**  
Cordillera Administrative Region  
**SCHOOLS DIVISION OF BAGUIO CITY**



May 27, 2025

**Division Memorandum**  
No. **328-2025**

**Addendum to Division Memorandum 304, s. 2025**  
**CONDUCT OF MANDATORY LEARNER'S HEALTH ASSESSMENT**

TO: All Public Schools District Supervisors  
Public Elementary and Secondary School Heads  
School Health and Nutrition Personnel  
Others Concerned

1. In reference to Division Memorandum No. 304, s. 2025 regarding the **CONDUCT of MANDATORY LEARNER'S HEALTH ASSESSMENT** scheduled from **June 9 to July 11, 2025**, all concerned are requested to **download and attach the School Health Record (SHD Form 1)** to the learners' enrollment forms.
2. This form must be duly **accomplished and signed by the parent or guardian** prior to submission. Kindly ensure that the completed forms are **submitted during enrollment** for the scheduled **Medical-Dental assessment**.

Link:

<https://docs.google.com/document/d/1Zpswm3lkfQkGPm70IcDsV13MqlMz643/edit?usp=sharing&ouid=104651763574971038598&rtpof=true&sd=true>

3. Immediate and wide dissemination of this memorandum is directed.

**SORAYA T. FACULO, PhD, CESO VI**  
Schools Division Superintendent

For the Schools Division Superintendent:

  
**CARMEL F. MERIS**  
OIC- Assistant Schools Division Superintendent



DATA PRIVACY NOTICE

The Department of Education shall engage in the collection of health / medical information for the purposes of tracking, provision of necessary health / medical interventions, and educational purposes. This information shall be processed in accordance with the provisions of the Data Privacy Act and the Data Privacy Policies of the Department.

This information shall be stored and held confidentially in accordance with the provisions of the Basic Education Act and may only be shared with other government agencies or third parties subject to Data sharing agreements and data privacy requirements for legitimate purposes only.

For inquiries, requests and concerns regarding your data privacy rights, please contact the data privacy compliance officer, team of the school, schools division office or regional office concerned.

MEDICAL HISTORY

Name of Learner				Grade	
Date of Birth		Age:		Sex:	
				Name of parent/guardian	
				Contact Number	

Instruction: Please put a check ( / ) on appropriate items and fill up blanks as indicated

1.

Does your child/ward have any allergies? ☐ Yes ☐ No if Yes, please identify below.

<input type="checkbox"/>	Medicine: Specify _____	<input type="checkbox"/>	Food: Specify _____
<input type="checkbox"/>	Pollen	<input type="checkbox"/>	Others: _____

2.

Does your child/ward have any ongoing medical condition? ☐ Yes ☐ No.

If Yes, please identify below:

<input type="checkbox"/>	Error of refraction (Eye ailment)	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Asthma (Lung ailment)	<input type="checkbox"/>	Bleeding disorder
<input type="checkbox"/>	Seizure (Convulsions)	<input type="checkbox"/>	Fracture/dislocation
<input type="checkbox"/>	Heart illness	<input type="checkbox"/>	Others: _____

3.

Did your child/ward ever have surgery/ hospitalization? ☐ Yes ☐ No.

If yes, please specify details: (when/where/what part of the body): \_\_\_\_\_

4.

Is your child currently taking treatment/medicines? ☐ Yes ☐ No.

If yes, please specify as to:

Kind of treatment/medicine: \_\_\_\_\_ Schedule/ dosage: \_\_\_\_\_

5.

Does your family have a history of the following conditions:

<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Stroke/ Heart attack
<input type="checkbox"/>	Cancer; what kind? _____	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	Kidney problems
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Others: _____

6.

Does your child/ward have exposure to cigarette/vape smoke at home? ☐ Yes ☐ No

7.

Other pertinent learner information: \_\_\_\_\_

I certify that the above information is correct and I hereby authorize the Department of Education to use, collect, and process the information for the purposes of the above stated.

Parent/ Guardian Name and Signature

Date

PARENT'S/GUARDIAN'S CONSENT FORM

Please put a check mark ( ✓ ) on the box provided for

Title of School Activities:

- ☐ Enrolment to Philhealth Konsulta package

☐ Philhealth ID number of member (parent/ guardian) \_\_\_\_\_
- ☐ Health/ Nutritional assessment      Weight \_\_\_\_\_      Height \_\_\_\_\_
- ☐ School Based Deworming (January and July of each year)
- ☐ Dental Assessment and Treatment
- ☐ School Based Immunization (Measles Containing Vaccine; Tetanus Toxoid for Grade 1 and 7, HPV vaccine grade 4 female)
- ☐ Weekly Iron Folic Acid Supplementation (for Grade 7 to 12 female learners)

Date/s of Activity: SY 2025-2026

As the parent/ guardian of the abovementioned learner, I hereby acknowledge that I have been informed of the details of these activities and voluntarily and freely elect to participate in this school health activities. Furthermore, I understand the risks associated with any activity and agree that the rules and regulations established for the said activities are for the safety and security of the participants, and thus agree to instruct my child or children to obey them.

Having understood all the aforementioned, I hereby consent to allow my child or children to participate, acknowledging all of the foregoing.

Signature of Parent/Guardian

Signature of Learner