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

DepED DIVISION OFFICE BAGUIO CITY
RELEASED
MAY 27 2025
By:
Time: CTRL No.:

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

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OPLAN KALUSUGAN SA DEPED

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	
Address						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.

	Medicine: Specify _____		Food: Specify _____
	Pollen		Others: _____

2. Does your child/ward have any ongoing medical condition? ____Yes ____No.
   If Yes, please identify below:

	Error of refraction (Eye ailment)		Anemia
	Asthma (Lung ailment)		Bleeding disorder
	Seizure (Convulsions)		Fracture/dislocation
	Heart illness		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:

	Tuberculosis		Stroke/ Heart attack
	Cancer: what kind? _____		Depression
	Diabetes Mellitus		Kidney problems
	Hypertension		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
  - o 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