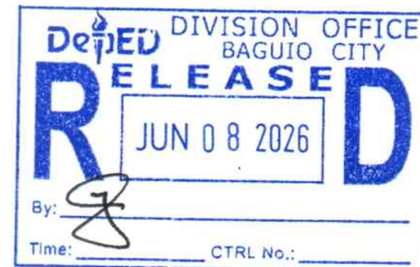


Republic of the Philippines
**Department of Education**
Cordillera Administrative Region
SCHOOLS DIVISION OF BAGUIO CITY

June 04, 2026

**DIVISION MEMORANDUM**
**No.** 389 - 2026

**CONDUCT OF MASS HEALTH ASSESSMENT FOR THE OPENING BLOCK FOR SCHOOL YEAR 2026–2027**

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

1. Pursuant to DepEd Order No. 009, s. 2026, titled "Guidelines on the Implementation of the Three-Term School Calendar in Basic Education", in preparation for the opening of classes for School Year 2026-2027, all learners shall undergo the Mass Health Assessment during the Opening Block period from June 8-11, 2026, to be conducted by the School Health and Nutrition in coordination with class advisers and school personnel.

2. This activity aims to ensure the physical and mental well-being of learners by establishing baseline health and nutritional status, identifying health-related concerns that may affect learning and development, promoting health awareness including oral hygiene practices, and facilitating timely interventions and updating of learner health records for School Year 2026–2027. The health assessment shall include but not limited to:
    a. General physical examination
    b. Vision screening
    c. Oral health examination
    d. Mental health assessment
    e. Review and updating of learner health records.

3. Classroom advisers are enjoined to assist in the distribution and retrieval of assessment forms, preparation of learners' master lists, organization of learner records, and coordination with parents or guardians as necessary.

4. The schedule of activities shall be as follows:

| Date | Activity | Person in Charge |
|---|---|---|
| DAY 1 – June 8, 2026 | • Start of height and weight assessment, vision screening, dental screening, and recording of learner data | SHN Team, with the assistance of classroom advisers and MAPEH teachers |
| DAY 2 – June 9, 2026 | • Continuation of assessments and screenings; retrieval of forms; consolidation of initial health data | SHN Team, with the assistance of classroom advisers and MAPEH teachers |
| DAY 3 – June 10, 2026 | • Continuation of assessments and screenings; review of mental health assessment forms; | SHN Team, with the assistance of classroom advisers and MAPEH teachers |

| | | |
|---|---|---|
| | identification of learners needing further assessment or referral | |
| DAY 4 – June 11, 2026 | • Completion of assessments and screenings; final consolidation and validation of data; endorsement and referral of identified learners | SHN Team, with the assistance of classroom advisers and MAPEH teachers |

5. To facilitate data consolidation, class advisers shall submit a soft copy of the Learners' Masterlist in Excel format to their respective SHN Personnel containing the following information:

   A. Complete Name
   B. Date of Birth (Mm/Dd/Yyyy)
   C. Sex
   D. Grade and Section

**The file should be on a folder per school and per grade level.**

6. Attached to this Memorandum are the following enclosures:
   **Enclosure No. 1** – Health Record Form
   **Enclosure No. 2** – Medical History Form
   **Enclosure No. 3** – Notification to Parents/Guardians on the Conduct of Mental Health Self-Assessment for Self-Assessment Learners Aged 10–19 Years Old
   **Enclosure No. 4** – Mental Health Self-Assessment Form

7. School heads are enjoined to ensure the smooth and efficient conduct of this activity in coordination with Division School Health and Nutrition Unit. Full cooperation from teaching and non-teaching personnel is expected.

8. For concern and clarifications, please contact Dr. Arlene Awing, Medical Officer III through messenger or mobile number 09054775638.

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

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

For the Schools Division Superintendent:

**SAMUEL T. EGSAEN JR. EdD, CESO VI**
Assistant Schools Division Superintendent

## HEALTH RECORD

Name: ____________________ School: ____________________

Grade & Section: ______________ Birthday: ____________ Age: ______

Gender: Male __ Female __

Height: _______ Weight: ________

To be submitted to class adviser after answering, If you Don't know your Height and weight we may take it for you

| COMMON HEALTH PROBLEMS | CHECK |
|---|---|
| A. SKIN AND SCALP | |
| 1. Pediculosis (Kuto/Lisa) | |
| 2. Tinea Flava (An-an) | |
| 3. Minor Injuries (Sugat/Gasgas) | |
| 4. Skin Allergy (dry skin/cracked skin) | |
| 5. Acne/Pimples | |
| 6. Warts (Kulogo/Tukak tukak) | |
| 7. Infected Wound | |
| 8. Dandruff/Scalp Disease | |
| B. EYES AND EARS | |
| 1. Squinting/Strabismus | |
| 2. Pale Conjunctiva | |
| 3. Stye/Hordeolum | |
| 4. Error of Refraction/Defective Vision | |
| 5. Impacted Cerumen | |
| 6. Otitis Media | |
| C. NOSE & MOUTH/RESPIRATORY DISEASE | |
| 1. Colds/Nasal Discharge | |
| 2. Cough | |
| 3. Defective Teeth/Dental Caries | |
| 4. Defective Speech | |
| 5. Cleft Lip/Cleft Palate | |
| D. THROAT AND NECK | |
| 1. Enlarged Tonsils | |
| 2. Inflamed Throat | |
| 3. Lymphadenopathy | |
| 4. Enlarged Thyroid Glands/Goiter | |
| E. HEART AND LUNGS | |
| 1. Normal | |
| 2. Irregular Heart Beat | |
| 3. Murmur | |
| 4. Abnormal Breath Sounds | |
| 5. Bronchial Asthma | |
| F. EXTREMITIES | |
| 1. Acquired | |
| 2. Congenital | |
| 3. Fracture | |
| G. GASTROINTESTINAL | |
| 1. Hyperacidity | |
| 2. Distended Abdomen | |
| H. PERSONAL HYGIENE | |
| 1. Dirty Teeth | |
| 2. Dirty Ears | |
| 3. Dirty Long Finger Nails | |
| 4. Halitosis/Bad Breath | |
| 5. Body Odor | |
| I. OTHERS | |
| 1. Medical condition that is confirmed by a doctor | |

*Please attach this to your ENROLLMENT FORM. The Medical Clinic will collect this for filing of your HEALTH RECORD. Thank you!

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.

*To be submitted to class adviser afeţer ansewring

## 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
  - ○ 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

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

**NOTICE TO PARENTS/GUARDIANS**

**CONDUCT OF MENTAL HEALTH SELF-ASSESSMENT FOR LEARNERS AGED 10–19 YEARS OLD**

Dear Parents/Guardians:

Greetings!

As part of the Department of Education's efforts to promote the well-being of learners, our school will conduct a Mental Health Self-Assessment for learners aged 10–19 years old during the opening block.

The activity aims to help identify learners who may benefit from appropriate support and guidance. The assessment is a screening tool only and is not intended to diagnose any mental health condition. All information gathered shall be treated with strict confidentiality and handled by authorized school personnel in accordance with Data Privacy and Child Protection policies.

For questions or concerns, you may contact the School Health and Nutrition Personnel or School Guidance Office.

Thank you for your support and cooperation.

Respectfully,

**School Health and Nutrition Unit**

**PAUNAWA SA MGA MAGULANG/TAGAPAG-ALAGA**

**PAGSASAGAWA NG MENTAL HEALTH SELF-ASSESSMENT PARA SA MGA MAG-AARAL NA MAY EDAD NA 10–19 TAONG GULANG**

Mahal na Magulang/Tagapag-alaga:

Magandang araw po!

Bilang bahagi ng programa ng Kagawaran ng Edukasyon para sa kapakanan ng mga mag-aaral, magsasagawa ang paaralan ng Mental Health Self-Assessment para sa mga mag-aaral na may edad na 10–19 taong gulang sa opening block.

Layunin nitong matukoy ang mga mag-aaral na maaaring mangailangan ng karagdagang suporta at paggabay. Ang pagtatasang ito ay isang screening tool lamang at hindi ginagamit upang magbigay ng diagnosis ng anumang kondisyon sa kalusugang pangkaisipan. Ang lahat ng impormasyong makakalap ay mananatiling kumpidensyal at pangangasiwaan lamang ng mga awtorisadong kawani ng paaralan alinsunod sa mga umiiral na patakaran sa Data Privacy at Child Protection.

Para sa mga katanungan, maaaring makipag-ugnayan sa School Health and Nutrition Personnel o School Guidance Office.

Maraming salamat po sa inyong suporta at pakikiisa.

Lubos na gumagalang,

School Health and Nutrition Unit

DepED MATATAG
BACONG PILIPINAS
Address: 82 Military Cutoff Rd, Baguio, Benguet, 2600
Telephone No.: (074) 665-1231
Email Address: baguio.city@deped.gov.ph
DepEd Tayo Baguio City
https://depedpines.com

**PARENT/GUARDIAN ACKNOWLEDGMENT / PAGKILALA NG MAGULANG O TAGAPAG-ALAGA**

I acknowledge that I have been informed about the conduct of the Mental Health Self-Assessment.

Kinukumpirma ko na ako ay naabisuhan tungkol sa pagsasagawa ng Mental Health Self-Assessment.

Name of Learner/Pangalan ng Mag-aaral: ____________________________

Grade & Section/Baitang at Seksyon: ____________________________

Name of Parent/Guardian/Pangalan ng Magulang o Tagapag-alaga: ____________________________

Signature/Lagda: ____________________ Date/Petsa: ____________________



**Address:** 82 Military Cutoff Rd, Baguio, Benguet, 2600
**Telephone No.:** (074) 665-1231
**Email Address:** baguio.city@deped.gov.ph
DepEd Tayo Baguio City https://depedpines.com

## MENTAL HEALTH SEFL ASSESSMENT FORM FOR LEARNERS AGES 10-19

Sagutin nang tapat ang mga sumusunod na mga katanungan. Ang iyong mga sagot ay CONFIDENTIAL.

* To be subbmited to class advise after answering

Petsa: ______________________

| Pangalan: | Kapanganakan: | Edad: |
|---|---|---|
| Tirahan/Address: | | |
| Sex: Lalake ☐ Babae ☐ | | |

| Katayuan: | | | | |
|---|---|---|---|---|
| | ☐ Estudyante/ Nag-aaral | ☐ Nagtatrabaho | ☐ Walang asawa | ☐ Naninirahan kasama magulang |
| | ☐ Hindi estudyante/ Hindi Nag aaral | ☐ Hindi nagtatrabaho | ☐ May kinakasama o live-in | ☐ Iba pang kasama sa bahay bukod sa magulang: ____________ |
| | | | ☐ May asawa | ☐ Naninirahan mag isa |

| Cellphone/Landline | Email Address/ FB account | |
|---|---|---|
| 1. Ikaw ba ay nakakaranas ng pananakit o pananakit sa inyong bahay, paaralan o trabaho | ☐ Oo | ☐ Hindi |
| 2. May mga pagkakataon ba na pinag-iisipan mong mglayas o umalis ng inyong bahay? | ☐ Oo | ☐ Hindi |
| 3. Nakaranas ka ba ng bullying o cyber bullying sa paaralan o sa trabaho | ☐ Oo | ☐ Hindi |
| 4. May pagkakataon ba na seryoso mong naisip na wakasan ang iyong buhay? | ☐ Oo | ☐ Hindi |
| 5. Naninigarilyo ka ba? | ☐ Oo | ☐ Hindi |
| 6. Uminom ka ba ng alak? | ☐ Oo | ☐ Hindi |
| 7. Nakakita ka na ba ng ipinagbabawal na gamot o drugs nang personal? | ☐ Oo | ☐ Hindi |
| 8. Ikaw ba ay nakaranas mgka boyfriend/ girlfriend? | ☐ Oo | ☐ Hindi |
| 9. Ikaw ba ay nakaranas makipag-sex/ makipagtalik? | ☐ Oo | ☐ Hindi |
| 10. Nakaranas ka ba na ikaw ay pinilit makipag-sex? | ☐ Oo | ☐ Hindi |
| 11. Ikaw ba ay nakaranas mabuntis o makabuntis | ☐ Oo | ☐ Hindi |
| 12. Gusto mo bang mga counsel o kumonsulta para matulungan ka? | ☐ Oo | ☐ Hindi |