



Republic of the Philippines
Department of Education
Region XII
Schools Division Office of Tacurong City

August 05, 2024

DIVISION MEMORANDUM

SGOD No. 094, s. 2024

**HEALTH APPRAISAL OF LEARNERS, TEACHING AND NON-TEACHING
PERSONNEL FOR SY 2024-2025**

TO: Asst. Schools Division Superintendent
Chiefs, CID and SGOD
Cluster Heads
Elementary and Secondary School Heads (Public)
This Division

1. In line with our commitment to promote the health and well-being of our Learners, Teaching and Non-teaching Personnel, the Schools Division of Tacurong City, through School Health Section will conduct Health Appraisal for this school year.
2. In addition, the schedule for the Health Appraisal is detailed in the attachment to this Memorandum.
3. The School Clinic-in-charge is advised to prepare necessary forms (SHD Form 1 and 2 attached to this Memorandum) to ensure smooth and efficient conduct of the Health Appraisal. Additionally, the School Clinic-in-charge should make sure to secure duly signed Parent and Child Consent Form.
4. The schedule may be subject to change due to unforeseen occurrences and/or overlapping of activities. In the event of a schedule change, the revised schedule will be posted.
5. For further information, please contact Dr. Katrina May B. Monsale-Dalayap, Medical Officer III through email, katrinamay.monsale@deped.gov.ph.
6. For wide dissemination and compliance to this Memorandum.


GILDO G. MOSQUEDA, CEO VI
Schools Division Superintendent

Enclosure: As stated

Reference: None

Allotment: None

To be indicated in the perpetual index under the following subjects:

HEALTH APPRAISAL SCHOOL LEARNERS

ABB/SGOD-SHS/DM/HEALTH APPRAISAL OF LEARNERS, TEACHING AND NON-TEACHING PERSONNEL FOR
AY 2024-2025/ August 05, 2024



Address: Alunan Highway, Poblacion, Tacurong City 9800

Telephone Numbers: (064)-562-4880; 0919-065-6425

Email: tacurong.city@deped.gov.ph

Website: depedtacurong.org



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Enclosure No. 1 to Division Memorandum SGOD no. 094, s. 2024

| SCHOOL | CLUSTER | DATE |
|----------------------------------|----------------|-----------------------|
| 1. Virginia F. Griño NHS | Secondary | August 8-9, 2024 |
| 2. Dr. Manuel J. Griño CES | North | August 13, 2024 |
| 3. New Lagao ES | North | August 14, 2024 |
| 4. Abang-Suizo Integrated School | North | August 15, 2024 |
| 5. Buenaflor ES | North | August 20, 2024 |
| 6. Maria A. Montilla ES | North | August 22, 2024 |
| 7. New Isabela CES | West | September 3-5, 2024 |
| 8. Kalandagan ES | West | September 11, 2024 |
| 9. Ma. Z. Bayya ES | West | September 12, 2024 |
| 10. J. Hector Lacson ES | West | September 17, 2024 |
| 11. San Pablo NHS | Secondary | September 24-25, 2024 |
| 12. San Emmanuel NHS | Secondary | October 1-2, 2024 |
| 13. Upper Katungal ES – Main | South | October 3, 2024 |
| 14. Josue Alcasid CS | South | October 15, 2024 |
| 15. Elisa P. Bernardo – Main | South | October 16, 2024 |
| 16. Lourdes Pama ES | South | October 17, 2024 |
| 17. Tacurong Pilot ES | Central | October 22-25, 2024 |
| 18. Tacurong National HS | Secondary | November 5-8, 2024 |
| 19. Amado Fernandez CES | East | November 13-14, 2024 |
| 20. Pedregosa-Acosta ES | East | November 19, 2024 |
| 21. Tina ES | East | November 20, 2024 |
| 22. San Emmanuel ES | East | November 21, 2024 |
| 23. Casilda P. Venus ES | East | November 27, 2024 |
| 24. San Rafael ES | East | November 28, 2024 |
| 25. Victorina P. Dasmariñas ES | East | December 3, 2024 |
| 26. Upper Katungal NHS | Secondary | December 4-5, 2024 |
| 27. Rajah Muda NHS | Secondary | December 10-11, 2024 |
| 28. Apolinario S. Bernardo NHS | Secondary | December 18, 2024 |



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| | | |
|------------------------------------|-------|-------------------|
| 29. San Antonio ES | North | December 19, 2024 |
| 30. Upper Katungal ES | South | January 8, 2025 |
| 31. Rajah Muda ES - Beam | South | January 9, 2025 |
| 32. Lancheta-Magallon ES | South | January 14, 2025 |
| 33. Elisa P. Bernardo ES - Beam | South | January 16, 2025 |



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Republic of the Philippines
DEPARTMENT OF EDUCATION
 Region _____
 Division of _____

 School Name/ID

| |
|---------------------------------------|
| SCHOOL HEALTH EXAMINATION CARD |
|---------------------------------------|

Name: _____

| | | | |
|--|------|-------|--------|
| | Last | First | Middle |
|--|------|-------|--------|

Date of Birth: _____ Birthplace: _____

Month / Day / Year

School ID: _____ Region: _____

Learner Reference Number (LRN): _____ Division: _____

Parent/Guardian: _____ Telephone No.: _____

Home Address: _____

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.

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

 Name and Signature of Child

 Name and Signature of Parent

Name : _____ LRN : _____

Medical History (For Learners)

1. Do you have any allergies? Yes No
If Yes, please identify below:
 Medicine
 Pollens
 Food
 Stinging Insects
 Others: _____
2. Do you have any ongoing medical condition? Yes No
If Yes, please identify below:
 Error of refraction
 Asthma
 Seizure
 Heart problem
 Anemia
 Bleeding disorder
 Hernia (painful bulge in the groin area)
 Others: _____
3. Have you ever had surgery/ hospitalization? Yes No
If Yes, please identify below:

4. Does anyone in your family have the following conditions:
 Tuberculosis
 Cancer If yes, what kind? _____
 Stroke
 Diabetes Mellitus
 Hypertension
 Depression
 Other _____
5. Exposure to cigarette/vape smoke at home? Yes No

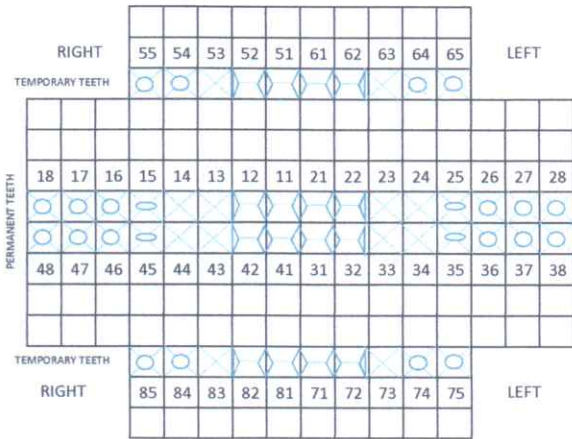
I certify that the above information are correct.

Name & Signature of Parent/Guardian

Date

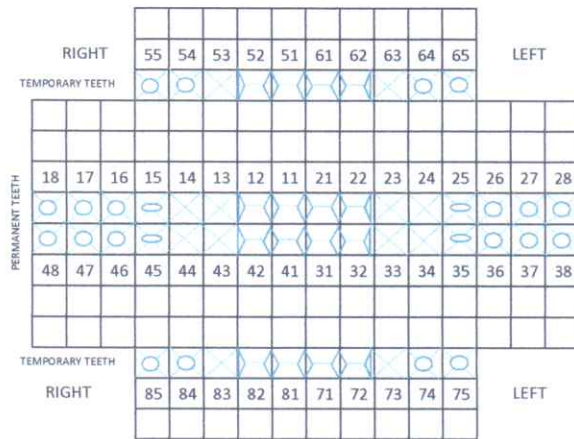
GRADE 4

S.Y. _____



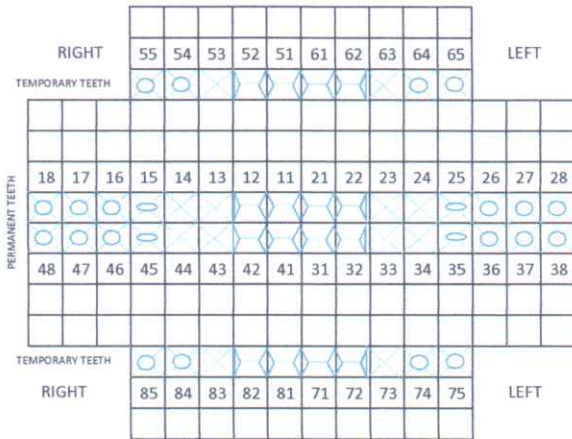
GRADE 5

S.Y. _____



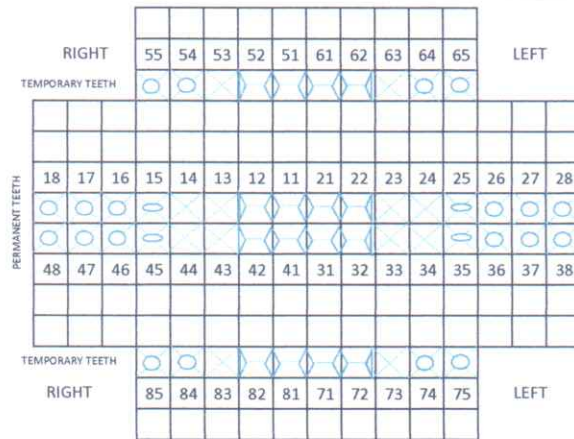
GRADE 6

S.Y. _____



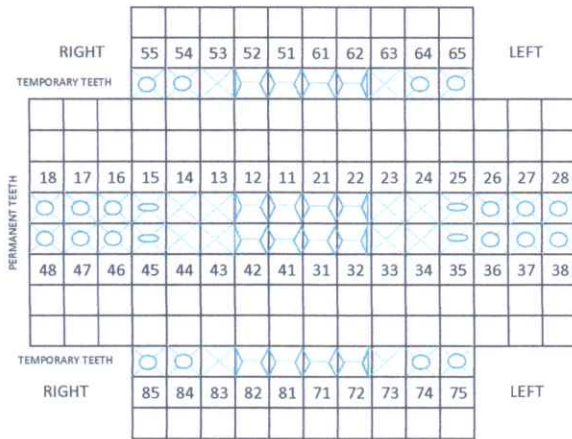
GRADE 7

S.Y. _____



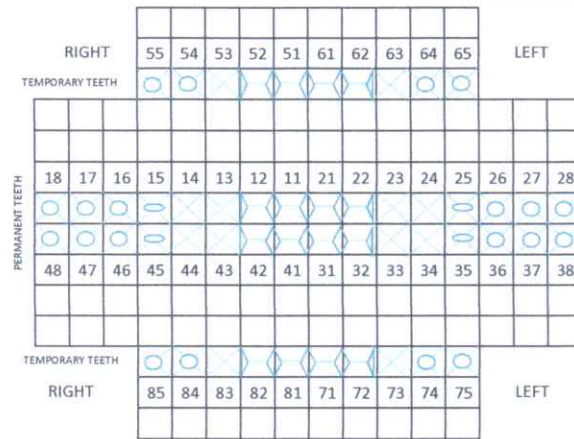
GRADE 8

S.Y. _____



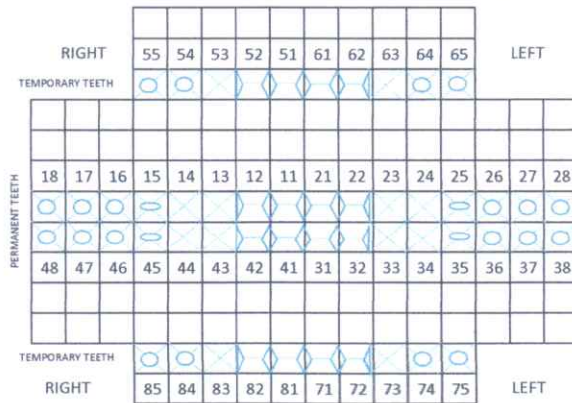
GRADE 9

S.Y. _____



GRADE 10

S.Y. _____



GRADE 11

S.Y. _____

