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

March 03, 2026

DIVISION MEMORANDUM
SGOD No. 041 s. 2026

2026 MEDICAL ASSESSMENT AND SCREENING OF ATHLETES AND COACHES FOR SOCCSKSARGEN REGIONAL ATHLETIC MEET

TO: Assistant Schools Division Superintendent
Chiefs, Curriculum Implementation and
Schools Governance and Operations Divisions
Cluster Heads
Elementary and Secondary School Heads
This Division

1. In line with the upcoming 2026 Soccsksargen Regional Athletic Association (SRAA) Meet event this April 2026, this office will conduct **medical assessment and screening** for the athletes, coaches and other participants from **March 3, 2026 to March 17, 2026 from 8:00am-12:00nn** in the different schools of SDO Tacurong City.

2. Below is the detailed schedule for the aforementioned activity:

Date	Venue	Clusters to be catered	Participants	Assigned personnel to conduct health assessment
March 3, 2026 8:00am-12:00nn	Tacurong Pilot Elementary School	Central Cluster	Athletes, Coaches, Technical Officials, Other participants	Akifa Guindo, MD Jonalee Arquiza, RN April Jane Duadua, RN Catherine Joy Maratas, RN Jancee Riveral, RN Angelie Delgado,RM Michael Jan Arquiza Nursing Students from SKEI/NDTC
March 4, 2026 8:00am-12:00nn	New Isabela Central Elementary School	West Cluster Elementary		
March 5, 2026 8:00am-12:00nn	Dr. Manuel J. Grino CES	North Cluster Elementary		
March 6, 2026 8:00am-12:00nn	Amado Fernandez Sr. CES	East Cluster Elementary		
March 10, 2026 8:00am-12:00nn	Tacurong National High School	High School		
March 11, 2026 8:00am-12:00nn	Virginia F. Grino National High School	High School		
March 12, 2026 8:00am-12:00nn	Josue S. Alcasis Central School	South cluster Elementary		
March 13, 2026 8:00am-12:00nn	Apolinario S. Bernardo National High School	High School		
March 16, 2026 8:00am-12:00nn	St John Early Learning Center Inc	Private students		
March 16, 2026 1:00am-3:00pm	Tacurong Pilot School	Private students		

3. All participants must undergo physical examination and must secure medical clearance before the sports events. With this, scheduled participants shall bring with them the following forms during the health assessment:

Address: Alunan Highway, Poblacion, Tacurong City 9800
Telephone Numbers: (064)-200-6316; 0919-065-6425
Email: tacurong.city@deped.gov.ph
Website: depedtacurong.org

a) **Learners** – updated SRAA medical forms, signed parental consent form, medical history signed and filled out by the parents, PhilHealth Member Data Record and PhilHealth Consent Forms (*See attached forms*).

b) **Coaches and Technical officials** – updated SRAA medical clearance form, photocopy of updated Teacher's Health Card with their recent annual laboratory results including **12Lead ECG w/ result**, PhilHealth Member Data Record and PhilHealth Consent Forms (*See attached forms*).

4. Coaches shall ensure the completeness of necessary documents of their delegates. **Incomplete forms shall not be catered,** and falsification of documents is strictly discouraged.

5. Nurses on duty are directed to pre-assess the athletes by recording their vital signs and ensuring they have no history of trauma, fractures, seizures, loss of consciousness, asthma exacerbations, or other conditions based on their medical history signed by parents, which may render them unfit for sports events. The nurses will then forward the forms to the Medical Officer for further assessment and final signature.

6. Failure to disclose any vital information about medical history to the examination team (ex. Cardiac problem) may result to disqualification of the participant. This division shall not be held liable for any untoward incident, complication, or adverse outcome that may arise **if a patient willfully withholds, conceals, or provides inaccurate information regarding his/her medical condition** or other vital health details which are crucial for clinical decision-making.

7. The medical team will accommodate a maximum total of 150 athletes, coaches and other participants per day, prioritizing those who have complete forms. **Participants who fail to attend** and do not arrive on the given schedule **will be rescheduled** after all the scheduled visits or they may opt to visit any other government health facility.

8. Additionally, participants are advised to arrive at their designated venues **at least 15 minutes before the assessment, groomed neatly and dressed appropriately with trimmed fingernails.** Coaches shall take full responsibility of the safety of their athletes during the activity.

9. **Participants with comorbidities** (cardiovascular diseases, previously diagnosed with heart attacks/stroke, pulmonary diseases, anemia, epilepsy, etc.), senior citizens, pregnant women, and immunocompromised participants **must initially secure clearance from their attending physician/specialist** and present it to the medical officer prior to the activity to avoid any

preventable health-related injuries and to ensure their safety during the actual event.

10. Furthermore, those who will be diagnosed with ailments during health assessment shall undergo treatment, monitoring, and medical reassessment prior to athletic meet. Referral to specialists may be done, if necessary.

11. For queries and clarification, please contact **Akifa H. Guindo, MD, Medical Officer III**, at mobile phone No. +63968-854-1253 or **Jonalee Arquiza, RN**, Division Nurse-In-Charge/MDNS focal person at mobile phone No. 0969-1882995.

12. For the information and guidance of all concerned.

GILDO G. MOSQUEDA, CEO VI
Schools Division Superintendent

Address: Alunan Highway, Poblacion, Tacurong City 9800
Telephone Numbers: (064)-200-6316; 0919-065-6425
Email: tacurong.city@deped.gov.ph
Website: depedtacurong.org

PhilHealth
Your Partner in Health

PMRF

PHILHEALTH MEMBER REGISTRATION FORM
UHC v.1 January 2020

PHILHEALTH IDENTIFICATION NUMBER (PIN)

PURPOSE:
☐ REGISTRATION ☐ UPDATING/AMENDMENT

Preferred KonSulTa Provider

REMINDERS:

1. Your PhilHealth Identification Number (PIN) is your unique and permanent number.
2. Always use your PIN in all transactions with PhilHealth.
3. For Updating/Amendment check the appropriate box and provide details to be accomplished and submit corresponding supporting documents.
4. Please read instructions at the back before filling-out this form.

I. PERSONAL DETAILS

	LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	NO MIDDLE NAME (Check if applicable only)	MONONYM (Check if applicable only)
MEMBER					☐	☐
MOTHER's MAIDEN NAME					☐	☐
SPOUSE (If Married)					☐	☐

DATE OF BIRTH (m m d d y y y y)

PLACE OF BIRTH (City/Municipality/Province/Country)
(Please indicate country if born outside the Philippines)

PHILSYS ID NUMBER (Optional)

SEX
☐ Male
☐ Female

CIVIL STATUS
☐ Single ☐ Annulled
☐ Married ☐ Widow/er
☐ Legally Separated

CITIZENSHIP
☐ FILIPINO ☐ FOREIGN NATIONAL
☐ DUAL CITIZEN

TAX PAYER IDENTIFICATION NUMBER (TIN) (Optional)

II. ADDRESS and CONTACT DETAILS

PERMANENT HOME ADDRESS
Unit/Room No./Floor | Building Name | Lot/Block/Phase/House Number | Street Name

Subdivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code

MAILING ADDRESS ☐ SAME AS ABOVE
Unit/Room No./Floor | Building Name | Lot/Block/Phase/House Number | Street Name

Subdivision | Barangay | Municipality/City | Province/State/Country (If abroad) | ZIP Code

Home Phone Number
(COUNTRY CODE + AREA CODE + TELEPHONE NUMBER)

Mobile Number (Required)

Business (Direct Line)

E-mail Address (Required for OFW)

III. DECLARATION OF DEPENDENTS

(Use additional form if necessary)

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./II)	MIDDLE NAME	RELATIONSHIP	DATE OF BIRTH (mm-dd-yyyy)	CITIZENSHIP	NO MIDDLE NAME (Check if applicable only)	MONONYM (Check if applicable only)	Check if with Permanent Disability
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

IV. MEMBER TYPE

DIRECT CONTRIBUTOR

☐ Employed Private
☐ Employed Government
☐ Professional Practitioner
☐ Self-Earning Individual
  ☐ Individual
  ☐ Sole Proprietor
  ☐ Group Enrollment Scheme
  _____
☐ Kasambahay
☐ Family Driver
☐ Migrant Worker
  ☐ Land-Based ☐ Sea-Based
☐ Lifetime Member
☐ Filipinos with Dual Citizenship / Living Abroad
☐ Foreign National
  PRA SRRV No. _____
  ACR I-Card No. _____

INDIRECT CONTRIBUTOR

☐ Listahanan
☐ 4Ps/MCCT
☐ Senior Citizen
☐ PAMANA
☐ KIA/KIPO
☐ Bangsamoro/Normalization
☐ LGU-sponsored
☐ NGA-sponsored
☐ Private-sponsored
☐ Person with Disability
PWD ID No. _____

PROFESSION: (Except Employed, Lifetime Members and Sea-based Migrant Worker)

MONTHLY INCOME:

PROOF OF INCOME:

For PhilHealth Use only:
☐ Point of Service (POS) Financially Incapable
☐ Financially Incapable

Continue at the back

V. UPDATING/AMENDMENT

Please check:	FROM	TO
☐ Change/Correction of Name (Last Name, First Name, Name Extension (Jr./Sr./III) Middle Name)		
☐ Correction of Date of Birth		
☐ Correction of Sex		
☐ Change of Civil Status		
☐ Updating of Personal Information/Address/ Telephone Number/Mobile Number/e-mail Address		

Under penalty of law, I hereby attest that the information provided, including the documents I have attached to this form, are true and accurate to the best of my knowledge. I agree and authorize PhilHealth for the subsequent validation, verification and for other data sharing purposes only under the following circumstances:

- As necessary for the proper execution of processes related to the legitimate and declared purpose;
- The use or disclosure is reasonably necessary, required or authorized by or under the law; and,
- Adequate security measures are employed to protect my information.

Member's Signature over Printed Name | **Date** | Please affix right thumbmark if unable to write

FOR PHILHEALTH USE ONLY

RECEIVED BY:

Full Name: _____

PRO/LHIO/Branch: _____

Date & Time: _____

INSTRUCTIONS

1. All information should be written in UPPER CASE/CAPITAL LETTERS. If the information is not applicable, write "N/A."
2. All fields are mandatory unless indicated as optional. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
3. A properly accomplished PMRF shall be accompanied by a valid proof of identity for first time registrants, and supporting documents to establish relationship between member and dependent/s for updating or request for amendment.
4. On the PURPOSE, check the appropriate box if for **Registration** or for **Updating/Amendment** of information.
5. Indicate preferred KonSulTa provider near the place of work or residence.
6. For PERSONAL DETAILS, all name entries should follow the format given below. Check the appropriate box if registrant has no middle name and/or with single name (mononym).

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME
SANTOS	JUAN ANDRES	III	DELA CRUZ

7. Indicate registrant's/member's name as it appears in the birth certificate.
8. The full mother's maiden name of registrant/member must be indicated as it appears in the birth certificate.
9. Indicate the full name of spouse if registrant/member is married.
10. Indicate the complete permanent and mailing addresses and contact numbers.
11. For updating/amendment, check the appropriate box to be updated/amended and indicate the correct data.
12. For MEMBER TYPE, check the appropriate box which best describes your current membership status.
13. For Direct Contributors, except employed, sea-based migrant workers and lifetime members, indicate the profession, monthly income and proof of income to be submitted.
14. For Self-earning individuals, Kasambahays and Family Drivers, indicate the actual monthly income in the space provided.
15. In declaring dependents, provide the full name of the living spouse, children below 21 years old, and parents who are 60 years old and above totally dependent to the member.
16. Dependents with disability shall be registered as principal members in accordance with Republic Act 11228 on mandatory PhilHealth coverage for all persons with disability (PWD).
17. The registrant must affix his/her signature over printed name (or right thumbmark if unable to write) and indicate the date when the PMRF was signed.

PhilHealth Konsulta Registration Form (PKRF)

INSTRUCTIONS

1. All Information should be written in UPPER CASE/CAPITAL LETTER.
2. All fields are mandatory.
3. If the beneficiary is dependent, use the dependent PIN.
4. If the beneficiary is below 21 years old, the signatory should be the parent/guardian.

TO BE FILLED - OUT BY THE BENEFICIARY

☐ MEMBER ☐ DEPENDENT

PIN: _____ DATE: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDLLE NAME)

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY / PROVINCE)

DATE OF BIRTH: _____ (MM/DD/YYYY) CONTACT NO: _____

☐ REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP)

☐ REGISTER ALL MY DECALRED MINOR DEPENDENTS
(please use additional form if neccesary)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

1ST CHOICE KPP: DEPED SDO TACURONG HEALTH CLINIC

ADDRESS: Tacurong Pilot Elementary School Compound (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

☐ TRANSFER

PREVIOUS KPP: _____

1ST CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

I HEREBY CERTIFY THAT I DID NOT AVAIL OF FIRST PATIENT ENCOUTER (FPE) IN MY PREVIOUS KPP.

_____
(Signature over Printed Name)

PHILHEALTH COPY

TO BE FILLED-OUT BY PHILHEALTH KONSULTA PERSONNEL

PHLHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

REGISTRATION NO.: _____ DATE REGISTERED: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDLLE NAME)

PIN: _____ DATE OF BIRTH: _____ (MM/DD/YYYY)

KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

_____
(Signature over Printed Name of Authorized Personnel)

BENEFICIARY COPY

PhilHealth Konsulta Registration Form (PKRF)

INSTRUCTIONS

1. All Information should be written in UPPER CASE/CAPITAL LETTER.
2. All fields are mandatory.
3. If the beneficiary is dependent, use the dependent PIN.
4. If the beneficiary is below 21 years old, the signatory should be the parent/guardian.

TO BE FILLED - OUT BY THE BENEFICIARY

☐ MEMBER ☐ DEPENDENT

PIN: _____ DATE: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDLLE NAME)

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY / PROVINCE)

DATE OF BIRTH: _____ (MM/DD/YYYY) CONTACT NO: _____

☐ REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP)

☐ REGISTER ALL MY DECALRED MINOR DEPENDENTS
(please use additional form if neccesary)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

1ST CHOICE KPP: DEPED SDO TACURONG HEALTH CLINIC

ADDRESS: Tacurong Pilot Elementary School Compound (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

☐ TRANSFER

PREVIOUS KPP: _____

1ST CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

I HEREBY CERTIFY THAT I DID NOT AVAIL OF FIRST PATIENT ENCOUTER (FPE) IN MY PREVIOUS KPP.

_____
(Signature over Printed Name)

PHILHEALTH COPY

TO BE FILLED-OUT BY PHILHEALTH KONSULTA PERSONNEL

PHLHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

REGISTRATION NO.: _____ DATE REGISTERED: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDLLE NAME)

PIN: _____ DATE OF BIRTH: _____ (MM/DD/YYYY)

KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

_____
(Signature over Printed Name of Authorized Personnel)

BENEFICIARY COPY

DEPED SDO TACURONG HEALTH CLINIC
SHOOLS DIVISION OFFICE OF TACURONG CITY
Alunan National highway tacurong city
Email: sdo.tacurong@gmail.com

Annex F: Photo Consent

PHOTO CONSENT FORM

I, _____ , with address
Name of Child / Pangalan ng bata
_____

_____ grant permission and give my consent to Deped SDO Tacurong Health Clinic for the use of my photo or picture as one of the requirements in the availment of Yakap Benefit.

By signing below, I hereby authorize my Yakap facility to save photo for post-audit monitoring purposes of Philhealth.

_____	_____	_____
Name of Parents / Name of Child	*Signature of Parents*	
Name of Yakap Beneficiary	Signature	Date

Note: The photograph should be colored and at least the size of 35mm width x 45mm height. It should have full face, front view and eyes open. Photo should present full head from the top of hair to bottom of the chin. The head should be in the center of the frame. There should be no distracting shadows on the face or background. The light should be even and balance to avoid shadows on the face.

Note: All Information should be written in UPPER CASE/CAPITAL LETTER

DEPED SDO TACURONG HEALTH CLINIC
Schools Division Office of Tacurong City
Alonan National Highway Bgry. Poblacion Tacurong City, Sultan Kudarat
Email: sdo.tacurong@gmail.com
Facebook: DepEd SDO Tacurong Health Clinic
Contact Number: 09692669233

PhilHealth YAKAP Accredited

PARENT CONSENT

I, _____, Parent/Guardian/myself of
Parent/Guardian Name

_____, hereby (name of parent/guardian or
Name of Child

student (name of child) if more than 21 years old) give my consent to register me/my child to a PhilHealth YAKAP facility, **DEPED SDO TACURONG HEALTH CLINIC** for CY **2026**.

I also give my free and voluntary consent to PhilHealth YAKAP facility, **DEPED SDO TACURONG HEALTH CLINIC**, to collect data, check-up my child for health screening, assessment and consultation at any time; transmit and process my child/children personal data and health records for the purpose of PhilHealth's payment, monitoring of the provider's performance and program implementation of the PhilHealth YAKAP benefit and Universal Health Care Act in accordance with Republic Act No. 10173, otherwise known as the "Data Privacy Act of 2012".

_____

(Name of Parents and Signature over Printed Name)

Date signed _____

Note: PLEASE WRITE IN CAPITAL LETTERS WHEN FILLING UP THE CONSENT.

DEPED SDO TACURONG HEALTH CLINIC
Schools Division Office of Tacurong City
Alonan National Highway Bgry. Poblacion Tacurong City, Sultan Kudarat
Email: sdo.tacurong@gmail.com
Facebook: DepEd SDO Tacurong Health Clinic
Contact Number: 09692669233

PhilHealth YAKAP Accredited

YAKAP Empanelment Slip
(Mutual Care Agreement)

PCU Transaction No.:_____

I, _____, born on _____with
Name of Child / Pangalan ng bata *mm / dd / yyyy*
Philhealth Identification Number _____ do hereby acknowledge that I empaneled to DepEd SDO Tacurong Health Clinic, until December 31st of 2026 where I can receive my benefits entitlements responsibilities as a beneficiary of the Primary Care Benefits Package:

1. Ensure my member data in Philhealth is updated;
2. Provide true and accurate information to the Primary Care Clinic;
3. Actively participate in the agreed-upon care plan;
4. Inform the Primary Care Clinic of any relevant changes that might affect the provision of my care; and
5. Respect clinic protocols and treatment guidelines.

We DepEd SDO Tacurong Health Clinic, with PhilHealth Accreditation Number P12039693, do hereby acknowledge that _____ is under our care until
Name of Child / Pangalan ng bata
December 31st 2026, and that we will provide the needed health service in accordance with the rules set by PhilHealth for its Primary Care Benefits Package. We also acknowledge the following responsibilities as a Primary Care Clinic:

1. Respect the beneficiary's rights including privacy and confidentiality;
2. Actively develop the care plan with the beneficiary;
3. Provide quality and accessible health service for the beneficiary; and
4. Ensure that the beneficiary receives their benefits entitlements aligned with the payment rules of PhilHealth Primary Care Benefit Package.

_____
Name and Signature of the Parents
Full Name of Beneficiary

AKIFA H. GUINDO, MD
Medical Officer III / Head School Health Section

Date signed: _____

Date signed: _____

Note: PLEASE WRITE IN CAPITAL LETTERS WHEN FILLING UP THE CONSENT.