



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

May 4, 2026

DIVISION MEMORANDUM

SGOD-2026- 066

**MEDICAL AND DENTAL CHECK UP OF ATHLETES AND COACHES FOR
PALARONG PAMBANSA 2026**

TO: Assistant Schools Division Superintendent
Chiefs, Curriculum Implementation and
Schools Governance and Operations Division
Cluster Head
School Head
Elementary and Secondary Schools (public)
This Division

1. In preparation for the participation of the division in the **Palarong Pambansa 2026**, all identified athletes, coaches and technical working group are hereby required to undergo a **comprehensive medical and dental examination** to ensure their fitness, safety, and readiness for the national sports event.
2. This activity aims to:
 - Assess the physical and dental health status of all athletes and coaches;
 - Ensure that all participants are medically fit to engage in strenuous sports activities;
 - Prevent possible health risks and ensure immediate intervention if needed.
3. The medical and dental check-up will be conducted on May 7, 2026, from 9:00 AM till 12:00 noon. The venue will be at the DepEd SDO Tacurong Health Clinic, TPES Compound, Tacurong City.
4. All participants are advised to bring the following:
 - Medical Certificate Form
 - Medical History (filled by parents/guardian)
 - Dental Health Record Form
 - Medical History Report (All Technical Working Group)
5. Participation in this activity is **mandatory**. Only those who are medically cleared will be allowed to join the Palarong Pambansa 2026.
6. For inquiries and clarifications, you may contact Ms. Jonalee Y. Arquiza, RN, through mobile number: 0969-188-2995.



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



Republic of the Philippines
Department of Education

Region XII
Schools Division Office of Tacurong City

7. Attached are the required forms for your reference.

8. Immediate dissemination and strict compliance with this memorandum are hereby directed.


GILDO G. MOSQUEDA, CEO VI
Schools Division Superintendent



JYA/SGOD-SHS/ MEDICAL AND DENTAL CHECK UP OF ATHLETES AND COACHES FOR PALARONG PAMBANSA 2026/MAY 4, 2026



Address: Alunan Highway, Poblacion, Tacurong City 9800
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Athlete's Name: _____

Date of Examination: _____

Birthdate: _____

MEDICAL HISTORY

This form must be completed and signed by the parent/guardian, prior to the physical examination, for review by examining practitioner.
 Explain 'YES' answers below with number of the question.

GENERAL QUESTIONS	YES	NO	REMARKS
1. Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports?	YES	NO	
2. Do you have an ongoing medical condition (like diabetes, asthma, anemia, infarctions, allergy)?	YES	NO	
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	YES	NO	
4. Do you have allergies to medicines, pollens, foods or stinging insects?	YES	NO	
5. Have you ever spent the night in a hospital?	YES	NO	
6. Have you ever had surgery?	YES	NO	
HEART HEALTH QUESTIONS ABOUT YOU			
7. Have you ever passed out or nearly passed out DURING exercise?	YES	NO	
8. Have you ever passed out or nearly passed out AFTER exercise?	YES	NO	
9. Have you ever had discomfort pain, tightness or pressure in your chest during exercise?	YES	NO	
10. Does your heart race or skip beats (irregular beats) during exercise?	YES	NO	
11. Has a doctor ever ordered a test for your heart? (ECG/EKG, echocardiogram, stress test)	YES	NO	
12. Do you get tightheaded or feel more short of breath than expected during exercise?	YES	NO	
13. Have you ever had an unexplained seizure?	YES	NO	
14. Do you get more tired or short of breath more quickly than your friends during exercise?	YES	NO	
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			
15. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden deaths before the age of 50 (including unexplained drowning, unexplained car accident, or sudden infant syndrome)	YES	NO	
16. Has anyone in your family had unexplained fainting, unexplained seizures or near drowning?	YES	NO	
BONE AND JOINT QUESTIONS			
17. Have you ever had an injury, like sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?	YES	NO	
18. Have you had any broken or fractured bones or dislocated joints?	YES	NO	
19. have you ever had an injury that requires x-ray for neck instability?	YES	NO	
20. Do you regularly use a brace or other assistive device?	YES	NO	
21. Do you have a bone, muscle or joint injury that bothers you?	YES	NO	
22. Do any of your joints become painful, swollen, feel warm or look red?	YES	NO	

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FOR SCHOOL SPORTS (Lower Meet up to Palarong Pambansa)



Republic of the Philippines
DEPARTMENT OF EDUCATION
 SOCCSKSARGEN

This form must be completed and signed by the parent/guardian, prior to the physical examination, for review by examining practitioner. Explain 'YES' answers below with number of the question.

MEDICAL QUESTIONS	YES	NO	REMARKS
23. Has a doctor ever told you that you have asthma or allergies?	YES	NO	
24. Do you cough, wheeze, experience chest tightness, or have difficulty breathing during or after exercise?	YES	NO	
25. Is there anyone in your family who has asthma?	YES	NO	
26. Have you ever used an inhaler or taken asthma medicine?	YES	NO	
27. Do you develop a rash or hives when you exercise?	YES	NO	
28. Were you born without or are you missing kidney, an eye, a testicle (males) or any other organ?	YES	NO	
29. Do you have groin pain or painful bulge or hernia in the groin area?	YES	NO	
30. Have you ever had Dengue hemorrhagic fever infection?	YES	NO	
31. Do you have any rashes, pressure sores or other skin problems?	YES	NO	
32. Have you ever had a head injury or concussion?	YES	NO	
33. Have you ever had a hit or blow to the head that caused confusion prolonged headache or memory problem?	YES	NO	
34. Have you ever had a history of seizure (convulsion)?	YES	NO	
35. Do you have headaches with exercise?	YES	NO	
36. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling?	YES	NO	
37. Have you ever been unable to move your arms or legs after being hit or falling?	YES	NO	
38. Have you ever become ill after exercising in the heat?	YES	NO	
39. Do you get frequent muscles cramps when exercising?	YES	NO	
40. Have you had any problems with your eyes or vision?	YES	NO	
41. Have you had any eye injuries?			
42. Do you wear glasses or contact lens?	YES	NO	
43. Do you wear protective eyewear such as goggles or face shield?	YES	NO	
44. Do you have any concerns that you would like to discuss with a doctor?	YES	NO	
45. Have you ever received dengvaxia vaccine? If Yes, how many dose?	YES	NO	
46. Do you have G6PD (Glucose 6 Phosphate Dehydrogenase) condition?	YES	NO	
FEMALES ONLY	YES	NO	
47. Have you ever had a menstrual period?	YES	NO	
48. Have you ever had menstrual cramps?	YES	NO	
49. How old were you when you had your first menstrual period?	YES	NO	
50. How many menstrual periods have you had in the last year?	YES	NO	
50. How many menstrual periods have you had in the last year?	YES	NO	

NOTES:

I do not know of any existing physical or addition health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in the athletic activities.

 Parent/Guardian Signature over Printed Name

 Athlete Signature over Printed Name



[Handwritten signatures]



MEDICAL CERTIFICATE

To Whom It May Concern:

This is to certify that I have personally examined _____
age _____ sex _____, and have found that he/she is physically fit unfit , during the time of
examination, to join and participate in the lower meets up to Palarong Pambansa.

Event: _____

Physical Examination

	School/Intrams/ District Meet		Unit/Division Meet		Regional Meet		Palarong Pambansa	
	Normal		Normal		Normal		Normal	
1. Eyes	YES	NO	YES	NO	YES	NO	YES	NO
2. Ears, Nose, Throat	YES	NO	YES	NO	YES	NO	YES	NO
3. Mouth and Teeth	YES	NO	YES	NO	YES	NO	YES	NO
4. Neck	YES	NO	YES	NO	YES	NO	YES	NO
5. Cardiovascular	YES	NO	YES	NO	YES	NO	YES	NO
6. Chest and Lungs	YES	NO	YES	NO	YES	NO	YES	NO
7. Abdomen	YES	NO	YES	NO	YES	NO	YES	NO
8. Skin	YES	NO	YES	NO	YES	NO	YES	NO
9. Genitalia-Hernia (male)	YES	NO	YES	NO	YES	NO	YES	NO
10. Muskuloskeletal: ROM	YES	NO	YES	NO	YES	NO	YES	NO
a. neck	YES	NO	YES	NO	YES	NO	YES	NO
b. spine	YES	NO	YES	NO	YES	NO	YES	NO
c. shoulder	YES	NO	YES	NO	YES	NO	YES	NO
d. arms/hands	YES	NO	YES	NO	YES	NO	YES	NO
e. hips	YES	NO	YES	NO	YES	NO	YES	NO
f. thighs	YES	NO	YES	NO	YES	NO	YES	NO
g. knees	YES	NO	YES	NO	YES	NO	YES	NO
h. ankles	YES	NO	YES	NO	YES	NO	YES	NO
i. feet	YES	NO	YES	NO	YES	NO	YES	NO
11. Neuromuscular (reflexes)	YES	NO	YES	NO	YES	NO	YES	NO

School Sports Meet/District Meet	Remarks/Findings:	<input type="checkbox"/> FIT <input type="checkbox"/> UNFIT
Physician/Medical Officer (signature over printed name)	Ht: _____ cm Wt: _____ kg BP: _____ mmHg PR: _____ bpm RR: _____ cpm	Date: _____
PRC LICENSE: _____ PTR NO. _____		
Unit/Division Meet	Remarks/Findings:	<input type="checkbox"/> FIT <input type="checkbox"/> UNFIT
Physician/Medical Officer (signature over printed name)	Ht: _____ cm Wt: _____ kg BP: _____ mmHg PR: _____ bpm RR: _____ cpm	Date: _____
PRC LICENSE: _____ PTR NO. _____		
Regional Meet	Remarks/Findings:	<input type="checkbox"/> FIT <input type="checkbox"/> UNFIT
Physician/Medical Officer (signature over printed name)	Ht: _____ cm Wt: _____ kg BP: _____ mmHg PR: _____ bpm RR: _____ cpm	Date: _____
PRC LICENSE: _____ PTR NO. _____		
Palarong Pambansa	Remarks/Findings:	<input type="checkbox"/> FIT <input type="checkbox"/> UNFIT
Physician/Medical Officer (signature over printed name)	Ht: _____ cm Wt: _____ kg BP: _____ mmHg PR: _____ bpm RR: _____ cpm	Date: _____
PRC LICENSE: _____ PTR NO. _____		

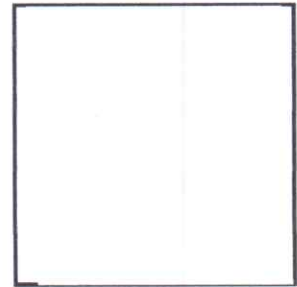
FOR SCHOOL SPORTS (Lower Meet up to Palarong Pambansa)



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DENTAL HEALTH RECORD



Name: _____
 Age: _____ Sex: _____ Birth Date: _____
 Event: _____
 Parent/Guardian: _____

CONDITION AND TREATMENT NEEDS

CONDITION RIGHT	55	54	53	52	51	61	62	63	64	65	LEFT					
TEMPORARY TEETH																
	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
TEMPORARY TEETH RIGHT	85	84	83	82	81	71	72	73	74	75	LEFT					
CONDITION																

YEAR LEVEL	REMARKS
DATE	
EXAMINATION	
SEALANT (G)	
PERMANENT FILLING	
ART	
EXTRACTION	
ORAL PROPHYLAXIS	
REFERRAL	
OTHER ORAL	
TREATMENT	

- | | |
|--|---|
| <p>SYMBOLS FOR MOUTH EXAMINATION</p> <ul style="list-style-type: none"> X - TOOTH INDICATED FOR EXTRACTION F - TOOTH INDICATED FOR FILLING HEAVY SHADE - TOOTH WITH TEMPORARY FILLING RC - RECURRENT CARIES RF - ROOT FRAGMENT M - MISSING TOOTH DU - DECUBITAL ULCER MAL - MALOCCLUSION FLU - FLUOROSIS Gn - NORMAL Gm - MODERATE GINGIVITIS (1-2 QUADRANTS) Gs - SEVERE GINGIVITIS (3-4 QUADRANTS) CMR - COMPLETE MOUTH REHAB (V) - SOUND ERUPTED PERMANENT TOOTH | <p>SYMBOLS FOR ACCOMPLISHMENT</p> <ul style="list-style-type: none"> XT - EXTRACTED PERMANENT TOOTH xt - EXTRACTED TEMPORARY TOOTH Am - AMALGAM FILLING Com - COMPOSITE FILLING ARTIFICIAL RESTORATION JC - JACKET CROWN I - INLAY OP - ORAL PROPHYLAXIS ZOE - ZINC OXIDE EUGENOL FILLING TF - TEMPORARY FILLING R - REFERRED TO PRIVATE DENTIST UN - UNERUPTED TOOTH |
|--|---|

District Meet _____ DENTIST (signature over printed name) PRC LICENSE PTR# Date Examined:	Remarks/Findings: WITH THIRD MOLAR: <input type="checkbox"/> YES <input type="checkbox"/> NO REFERRED FOR DENTAL TREATMENT: <input type="checkbox"/> YES <input type="checkbox"/> NO QUALIFIED TO PARTICIPATE: <input type="checkbox"/> YES <input type="checkbox"/> NO
Division Meet _____ DENTIST (signature over printed name) PRC LICENSE PTR# Date Examined:	Remarks/Findings: WITH THIRD MOLAR: <input type="checkbox"/> YES <input type="checkbox"/> NO REFERRED FOR DENTAL TREATMENT: <input type="checkbox"/> YES <input type="checkbox"/> NO QUALIFIED TO PARTICIPATE: <input type="checkbox"/> YES <input type="checkbox"/> NO
Regional Meet _____ DENTIST (signature over printed name) PRC LICENSE PTR# Date Examined:	Remarks/Findings: WITH THIRD MOLAR: <input type="checkbox"/> YES <input type="checkbox"/> NO REFERRED FOR DENTAL TREATMENT: <input type="checkbox"/> YES <input type="checkbox"/> NO QUALIFIED TO PARTICIPATE: <input type="checkbox"/> YES <input type="checkbox"/> NO
Palarong Pambansa _____ DENTIST (signature over printed name) PRC LICENSE PTR# Date Examined:	Remarks/Findings: WITH THIRD MOLAR: <input type="checkbox"/> YES <input type="checkbox"/> NO REFERRED FOR DENTAL TREATMENT: <input type="checkbox"/> YES <input type="checkbox"/> NO QUALIFIED TO PARTICIPATE: <input type="checkbox"/> YES <input type="checkbox"/> NO

FOR SCHOOL SPORTS (Lower Meet up to Palarong Pambansa)



[Handwritten signatures]



Republic of the Philippines
Department of Education
 SOCCSKSARGEN REGION

MEDICAL HISTORY REPORT

Date: _____

Last Name	First Name	Middle Initial	Age	Sex	Civil Status
Permanent Home Address					
Contact Number					
Date of Birth	Place of Birth	Religion			

Instructions: The instructions contained hereto and in the other medical forms are pertinent and vital. They shall be part of the personnel's medical records.

FAMILY MEDICAL HISTORY

a. Has anyone in your family suffered from the following:

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Diabetes				Hepatitis			
Stroke				Kidney Disease			
Heart Disease				Cancer			
Hypertension				Bleeding Disorders			
Asthma				Mental Disorder			
Pulmonary TB				Thyroid disease			

b. Do you have any family member who died of heart disease yes no
 If yes, indicate relationship and age at the time of death _____

PERSONAL-SOCIAL HISTORY

Smoking Sticks/day _____ since _____
 Stopped smoking when: _____
 Alcohol _____ x _____



Prime Regional Government Center, Brgy. Carpenter Hill, City of Koronadal
 Telephone Nos.: (083) 2288825/ (083) 2281893
 Email Address: region12@deped.gov.ph
 Website: depedroxii.org



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Certificate No. PPOP QMS 24 93 9190



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Stopped drinking when: _____

OBSTETRIC-GYNECOLOGIC HISTORY (if applicable)

Menarche: _____ Interval: _____ Duration: _____ Amount: _____ Dysmenorrhea: _____

OB Score (TPAL score): _____

Last Menstrual Period: _____ PAP Smear: _____

Current Method of Contraception (if there's any) _____

VACCINATION HISTORY

Name of Vaccine	Date Received	Dose	Remarks

MEDICATION HISTORY

A. Current Medications you are taking if there are any:

B. Food and Drug Allergies

REVIEW OF SYSTEMS



Prime Regional Government Center, Brgy. Carpenter Hill, City of Koronadal
 Telephone Nos.: (083) 2288825/ (083) 2281893
 Email Address: region12@deped.gov.ph
 Website: depedroxii.org



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Republic of the Philippines
Department of Education
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General	
EENT	
Lungs	
Cardiovascular	
Gastrointestinal	
Genitourinary	
Musculoskeletal	
Skin	
Neurologic	
Menstrual Problems	
Breast	
Emotional Problems	

I certify that the above information are true and correct to the best of my knowledge. I understand that failure to disclose pertinent personal medical information may affect the assessment and evaluation of the medical officer.

I hold myself liable for perjury, falsehood, misrepresentation or omission or act of dishonesty, if there is willful failure to disclose pertinent medical information. I attest to the truthfulness of this undertaking and submit to the legal and administrative consequences thereof if ever the statements above are wanting truth and substance.

 Date
 Name

Employee Signature over Printed

 Signature over Printed Name
 Medical Officer IV



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