Republic of the Philippines
Department of Education
SOCCSKSARGEN REGION
SCHOOLS DIVISION OF SARANGANI

20 May 2025

DIVISION MEMORANDUM
No. **072** , s. 2025

CONDUCT OF MANDATORY LEARNERS HEALTH ASSESSMENT FOR SY 2025-2026

To: Assistant Schools Division Superintendent
Public Schools District Supervisors
Public Elementary and Secondary School Heads
Public Elementary and Secondary District Nurses
Teaching and Non-Teaching Personnel
School Health Section Personnel
All Others Concerned

1. In reference to DepEd Order No. 12, Series of 2025 entitled ***"Multi-year implementing guidelines on the School Calendar and Activities***," under the section **Preparation for the Opening of Classes** for all learners during **Brigada Eskwela** and up to three (3) weeks after the start of classes, from **June 9, 2025 – July 4, 2025**. This shall be conducted by the designated health personnel of the school in coordination with class advisers.

2. This activity aims to carry out the following:

2.1 General Physical Examination/Inspection
2.2 Anthropometric Assessment (Height, Weight, BMI)
2.3 Vision and Hearing Screening
2.4 Oral Health Examination
2.5 Assessment of Immunization Status
2.6 Review of Medical and Family History
2.7 Formulation of Comprehensive Masterlist of Learners
2.8 Facilitation of Learners' Enrollment in the National Health Insurance Progress, in coordination with the Philippine Health Insurance Corporation's Philhealth Konsulta, by distributing the Philhealth Konsulta Registration Form (PKRF) (see Enclosure No. 1) and collecting the completed forms for the consolidated report.

3. The School Health Examination Card from the Bureau of Learners Support Services – School Health Division (BLSS – SHD) shall be the standard form use for the assessment (see enclosure No. 2) and shall be attached to form 137 to ensure continuity of the learner's health profile as they progress to the next grade level.

4. All Learners shall undergo a mandatory health assessment, all missed assessment shall be perform on the catch-up activities during *OK sa DepEd*, as designated health week in July 2025.

Address: Capitol Compound, Maribulan, Alabel, Sarangani Province
Telephone No.: (083) 508-2039
Website: www.depedsaragani.com
Email Address: sarangani@deped.gov.ph

5. For inquiries, contact Renz Louis Bautista RN at 09098243043.

6. For information and strict compliance.

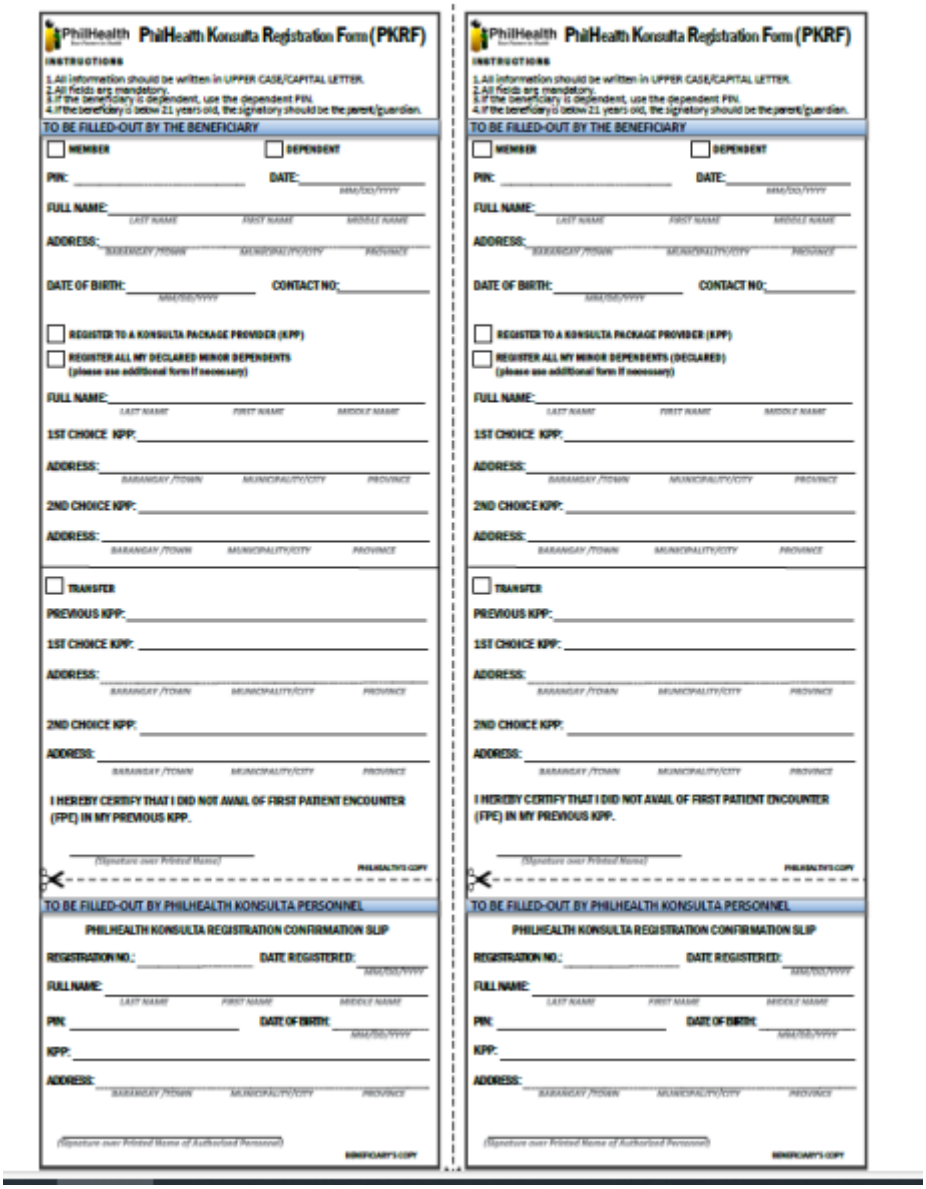
RUTH L. ESTACIO PhD, CESO V
Schools Division Superintendent

Encl.: As stated
Reference: As stated
To be indicated in the Perpetual Index
under the following subjects:

ASSESSMENTS
LEARNERS

RLB/SGOD-SHS/DM – conduct of mandatory learners health assessment for sy 2025-2026
0451/May 19, 2025

Enclosure 1: Philhealth Konsulta Registration Form



PhilHealth 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 / MIDDLE NAME)

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

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

☐ REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP)

☐ REGISTER ALL MY DECLARED MINOR DEPENDENTS
(please use additional form if necessary)

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

1ST CHOICE KPP: _____

ADDRESS: _____ (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 ENCOUNTER (FPE) IN MY PREVIOUS KPP.

_____ (Signature over Printed Name)

PHILHEALTH'S COPY

TO BE FILLED-OUT BY PHILHEALTH KONSULTA PERSONNEL

PHILHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

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

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

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

KPP: _____

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

(Signature over Printed Name of Authorized Personnel)

BENEFICIARY'S COPY

PhilHealth 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 / MIDDLE NAME)

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

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

☐ REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP)

☐ REGISTER ALL MY MINOR DEPENDENTS (DECLARED)
(please use additional form if necessary)

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

1ST CHOICE KPP: _____

ADDRESS: _____ (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 ENCOUNTER (FPE) IN MY PREVIOUS KPP.

_____ (Signature over Printed Name)

PHILHEALTH'S COPY

TO BE FILLED-OUT BY PHILHEALTH KONSULTA PERSONNEL

PHILHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

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

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

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

KPP: _____

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

(Signature over Printed Name of Authorized Personnel)

BENEFICIARY'S COPY

Enclosure No. 2 Health Examination Card

SHD Form1-B

REPUBLIC OF THE PHILIPPINES
DEPARTMENT OF EDUCATION
BUREAU OF LEARNER SUPPORT SERVICES - SCHOOL HEALTH DIVISION
Pasig City

SCHOOL HEALTH EXAMINATION CARD

Name: _____ School ID: _____
Last First Middle

LRN: _____

Date of Birth: _____ Region: _____
Month Day Year

Birthplace: _____ Division: _____

Parent/Guardian: _____ Telephone No.: _____

Address: _____

Medical/Nursing Findings

	Grade K/ SPED	Grade 1/ SPED	Grade 2/ SPED	Grade 3/ SPED	Grade 4/ SPED	Grade 5/ SPED	Grade 6/ SPED	Grade 7/ SPED	Grade 8/ SPED	Grade 9/ SPED	Grade 10/ SPED	Grade 11/ SPED	Grade 12/ SPED	
	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	
Date of Examination														
Height (in cm)														
Weight (in kg)														
Nutritional Status (NS) (BMI/Wt-for-Age)														
Nutritional Status (NS) (Height-for-Age)														
4Ps Beneficiary (V or X)														
SBFP Beneficiary (V or X)														
Deworming (V or X)	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	1st / 2nd	
Iron Supplementation (V or X)														
Immunization (Specify what kind)														
Menarche														
Temperature/BP														
Heart Rate/Pulse Rate/Respiratory Rate														
Vision Screening using appropriate chart														
Auditory Screening (Tuning Fork)														
Skin/ Scalp														
Eyes/Ears/Nose														
Mouth/Throat/Neck														
Lungs/Heart														
Abdomen														
Deformities														
Others, specify														
Examined by:														

NS	Vision/ Auditory Screening			Skin/Scalp	Eye/ Ear/Nose	Mouth/ Neck/Throat	Heart/Lungs	Abdomen	Deformities
a. Normal Weight	Vision			a. Normal	a. Normal	a. Normal	a. Normal	a. Normal	a. Acquired (Specify)
b. Wasted	a. Passed	L	R	b. Presence of Lice	b. Inflamed Eye Lid	b. Enlarged tonsil	b. Rales	b. Distended	b. Congenital (Specify)
c. Severely Wasted/Underwt	b. Failed	L	R	c. Redness of Skin	c. Eye Redness	c. Presence of lesions	c. Wheeze	c. Abdominal Pain	
d. Overweight	Auditory			d. White Spots	d. Ocular Misalignment	d. Inflamed pharynx	d. Murmur	d. Tenderness	
e. Obese	a. Passed	L	R	e. Flaky Skin	e. Pale Conjunctiva	e. Enlarged lymphnodes	e. Irregular heart rate	e. Dysmenorrhea	
f. Normal Height	b. Failed	L	R	f. Impetigo/boil	f. Matted Eyelashes	f. Others, specify	f. colds	f. Others, Specify	
g. Stunted				g. Hematoma	g. Eye Discharge		g. Cough		
h. Severely Stunted				h. Bruises/ Injuries	h. Ear discharge		h. Others, specify		
i. Tall				i. Itchiness	i. Impacted cerumen				
				j. Skin Lesions	j. Mucus discharge				
				k. Acne/Pimple	k. Nose Bleeding (Epistaxis)				
				l. Capilary refill greater than 3 sec	l. Others, specify				
				m. others, specify					

Note: Use letter to record ailments and Place X if not examined

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