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

23 Sep 2025

DIVISION MEMORANDUM
SGOD-2025-171

2025 MEDICAL & DENTAL HEALTH ASSESSMENT AND SCREENING OF ATHLETES AND COACHES

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 preparation for the upcoming 2025 Sarangani Province Athletic Association (SPAA) Meet event this 2025-2026, the School Health Section of the SGOD will conduct medical and dental health assessment and screening for SDO Sarangani participants across various schools in Sarangani.

2. The detailed schedule for the aforementioned activity will be announced. Schools or district sports coordinators may coordinate and schedule their assessment through **Ms. Junelette Magbunga, PDO-I Sports Coordinator**.

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

a) **Learners** – updated SPAA medical and dental forms, signed parental consent form, and medical history forms signed and filled out by parents.
b) **Coaches and Technical officials** – updated SPAA medical clearance form, photocopy of updated Form 86 with their recent annual laboratory results, and completed health declaration forms (Annex A and B).

4. Coaches shall ensure the completeness of the necessary documents of their delegates. **Incomplete forms shall not be catered** to, 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. Completed forms will be forwarded to the Dentist and Medical Officer for further assessment and final signature.

6. The medical team will accommodate a maximum total of 100 athletes, coaches, and other participants per day, prioritizing those who have completed

forms. **Athletes 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.

7. 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 for the safety of their athletes during the activity.

8. **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 before the activity to avoid any preventable health-related injuries and to ensure their safety during the actual event.

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

10. For queries and clarification, please contact **Lyn Frances Dominique P. Gumban, MD, Medical Officer III**, at the mobile phone number. +63918-227-6157 or **Estylinda G. Tudayan, RN**, Division Nurse-In-Charge/MDNS alternate focal person at mobile phone No. 0908-810-8005.

11. For the information and guidance of all concerned.

Digitally signed by
Estacio Ruth Laroscain
Adobe Acrobat
version:
2023.008.20470

RUTH L. ESTACIO PhD, CESO V
Schools Division Superintendent

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

PROGRAMS
SPORTS

Adriano A. Daligdig/SGOD/MLA – 2025 medical & dental health assessment and screening of athletes and coaches
0893/September 23, 2025

ANNEX A

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 ang age at the time of death _____

PERSONAL-SOCIAL HISTORY

Smoking Sticks/day _____ since _____

Stopped smoking when: _____

Alcohol _____x _____

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

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

Employee Signature over Printed Name

Signature over Printed Name
Medical Officer IV

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

ANNEX B

PHYSICAL EXAMINATION REPORT

Date: _____

Last Name	First Name	Middle Initial	Age	Sex	Civil Status
Permanent Home Address					
Contact Number					
Date of Birth	Place of Birth	Religion			
THIS PART IS TO BE FILLED-UP BY MEDICAL STAFF/MEDICAL OFFICER					
Height (cm)	Weight (kg)	BMI (weight in kg / height in meter squared)			
VITAL SIGNS					
BLOOD PRESSURE (MMHG)	HEART RATE (BPM)	RESPIRATORY RATE (CPM)	TEMP		
PHYSICAL EVALUATION		Describe every abnormality in detail. Enter number **Note: Describe**			
Check each item in appropriate column	Normal	Abnormal			
1. Skin					
2. Head, Face and Scalp					
3. Eyes					
4. ENT					
5. Lungs and Chest					
6. Heart					

7. Peripheral Vascular			
8. Abdomen			
9. Reproductive			
10. Extremities			
11. Spine, Musculoskeletal			
12. Neurologic			
Obstetric Score G____P_____ (_____ _____) LMP: _____			

DIAGNOSTIC/ LABORATORY EXAMINATION		
Chest Xray		ECG
HEMATOLOGY	**URINALYSIS**	**BLOOD CHEMISTRY**
Complete Blood Count		
OTHER TEST/ ANCILLARY PROCEDURES:		
ASSESSMENT/DIAGNOSIS		

RECOMMENDATIONS

I hereby certify that I have seen and thoroughly examined this employee together with his/her laboratory results that lead to the above recommendations.

_____ _____

SIGNATURE OVER PRINTED NAME DATE EVALUATED

MEDICAL OFFICER III