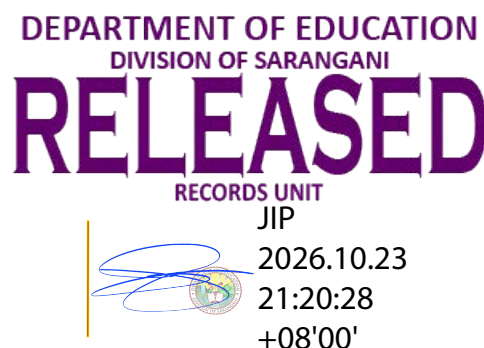




Republic of the Philippines
Department of Education
SOCCSKSARGEN REGION
SCHOOLS DIVISION OF SARANGANI



20 Oct 2026

DIVISION MEMORANDUM

SGOD-2026-300

SPAA 2026 MEDICAL AND DENTAL HEALTH ASSESSMENT AND SCREENING OF
ATHLETES AND COACHES

To: Assistant Schools Division Superintendent
Chief Education Supervisors
Medical Officer III
District Nurses
Public Schools District Supervisors
Public Elementary and Secondary School Heads
All Others Concerned

1. In preparation for the upcoming **2026 Sarangani Province Athletic Association (SPAA) Meet for School Year 2026-2027**, the School Health Section of the Schools Governance and Operations Division (SGOD) shall conduct a **Medical and Dental Health Assessment and Screening** for athletes, coaches, and technical officials from various schools in the Schools Division Office (SDO) of Sarangani.

2. The Medical and Dental Health Assessment and Screening shall be conducted according to the schedule below. Schools and District Sports Coordinators are advised to coordinate with **Ms. Junelette D. Mabunga, Division Sports Coordinator**, regarding the specific venue and time of assessment.

DATE	MUNICIPALITY
October 26-27, 2026	Maitum
October 28, 2026	Kiamba
October 29-30, 2026	Maasim
November 3-4, 2026	Alabel
November 5-6, 2026	Malungon
November 9-10, 2026	Malapatan
November 11-12, 2026	Glan

3. All participants shall undergo a physical examination and secure a medical clearance prior to their participation in the sports event. During the health assessment, participants shall bring the following documents:



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A. Learners

- Updated SPAA Medical and Dental Forms;
- Signed Parental Consent Form; and
- Medical History Form duly accomplished and signed by parents/guardians.

B. Coaches and Technical Officials

- Updated SPAA Medical Clearance Form;
- Photocopy of the updated Form 86 with recent annual laboratory results; and
- Accomplished Health Declaration Forms (Annexes A and B).

4. Coaches shall ensure the completeness and accuracy of the required documents of their delegates. Participants with incomplete requirements shall not be accommodated. Submission of falsified documents is strictly prohibited and shall be dealt with in accordance with existing DepEd policies.

5. Nurses assigned during the activity shall conduct an initial assessment of athletes by recording vital signs and reviewing their medical history. Particular attention shall be given to any history of trauma, fractures, seizures, loss of consciousness, asthma exacerbations, or other medical conditions that may affect the participant's fitness for sports activities. Completed forms shall then be endorsed to the Dentist and Medical Officer for further evaluation and final clearance.

6. The medical team shall accommodate a maximum of **100 participants per day**, including athletes, coaches, and other delegates, with priority given to those who have completed all required documents. Participants who fail to appear on their scheduled date shall be accommodated only after all scheduled participants have been served, or they may seek assessment and clearance from any government health facility.

7. Participants are advised to arrive at their designated assessment venue at least **15 minutes before their scheduled time**, properly groomed, appropriately dressed, and with trimmed fingernails. Coaches shall ensure the safety and welfare of their athletes throughout the activity.

8. Participants with comorbidities such as cardiovascular diseases, previous heart attack or stroke, pulmonary diseases, anemia, epilepsy, and other significant medical conditions, including senior citizens, pregnant women, and immunocompromised individuals, shall first secure a medical clearance from their attending physician or specialist. Said clearance shall be presented to the Medical Officer prior to the assessment to help prevent health-related risks and ensure the participant's safety during the athletic meet.





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9. Participants found to have medical or dental conditions during the assessment shall undergo appropriate treatment, monitoring, and reassessment prior to the conduct of the athletic meet. Referral to appropriate specialists may be made when deemed necessary.

10. For inquiries and clarifications, please contact Dr. Lyn Frances Dominique P. Gumban, Medical Officer III, at +63 918 227 6157, or Dr. Monette Faye P. Macamay, Dentist II, at +63 926 626 8353.

11. Immediate and wide dissemination of this Memorandum is desired.


Digitally signed by
Frinal Nelyn Botes
Adobe Acrobat version:
2023.008.20470
ATTY. NELYN B. FRINAL, CESO VI
Schools Division Superintendent

Encl.: As stated

Reference: As stated,

To be indicated in the Perpetual Index
under the following subjects:

HEALTH EDUCATION
TRAINING PROGRAMS
SPORTS

LFDPG/MFPM/SGOD-SHNS/DM – SPAA 2026 medical and dental health assessment and screening of athletes and coaches
0836/October 20, 2026



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Annex 1



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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 _____							



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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			



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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

Signature over Printed Name

Signature over Printed Name

Medical Officer III



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ANNEX 2



Republic of the Philippines
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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					
Check each item in appropriate column	Normal	Abnormal			
1. Skin					
2. Head, Face and Scalp					
3. Eyes					
4. ENT					
5. Lungs and Chest					



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6. Heart			
7. Peripheral Vascular			
8. Abdomen			
9. Reproductive			
10. Extremities			
11. Spine, Musculoskeletal			
12. Neurologic			
Obstetric Score			
G ____ P ____ (____)			
LMP: _____			



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



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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 MEDICAL OFFICER III	DATE EVALUATED



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