



Republic of the Philippines  
**DEPARTMENT OF EDUCATION**  
Region VIII  
**SCHOOLS DIVISION OF CATBALOGAN CITY**



July 16, 2018

**DIVISION MEMORANDUM**  
NO. **751**, S. 2018

**(OPLAN KALUSUGAN) OK SA DEPED "ALL IN ONE HEALTH WEEK"**

**TO: Schools Division Superintendent**  
**Asst. Schools Division Superintendent**  
**Education Program Supervisor**  
**Public and Private Elementary and Secondary School Heads**  
**All others concerned**

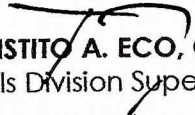
1. In compliance to Regional Memorandum No. 0463, s. 2018, titled: **OPLAN KALUSUGAN SA DEPARTMENT OF EDUCATION (OK SA DEPED)**, this office enjoins all Public and Private Elementary and Secondary Schools to celebrate the DepEd Catbalogan City Division OK sa DepEd "All in One Health Week".
2. OK sa DepEd is a convergence of DepEd's health programs, plans, policies, and activities for effective and efficient implementation at the school level, in partnership with various stakeholders. OK sa DepEd shall focus on the 5 major school health programs such as the School-Based Feeding Program, National Drug Education Program, Adolescent Reproductive Health, Wash in Schools and Medical, Dental and Nursing Services.
3. In connection to this, the DepEd Catbalogan City Division will conduct the launching of Oplan Kalusugan sa Department of Education (OK sa DepEd) on July 20, 2018, 8:00 am at Tia Anitas 2<sup>nd</sup> floor, Catbalogan City, Samar. Lunch and 2 snacks will be served to the guests and participants.
4. Listed below are the suggested activities but not limited to:
  - Orientation on policies, guidelines and evaluation tool for personnel, PTA, and partners on the conduct of deworming, immunization, school-based feeding, random drug testing, medical, dental check-ups and other school health programs as well as parental consent and data gathering with emphasis on the importance of a reliable and updated database;
  - Conduct of school health service activities such as Nursing and Dental Examination, Referral, Deworming, Vision and Auditory screening, Height- and Weight-taking and Nutritional assessment,
  - Monitoring & Implementation of the Wins Program,
  - Monitoring on the implementation of GPP
  - Monitoring on SBFP implementing school,
  - Monitoring school canteens to feature healthy food and beverage choices
  - Conduct an advocacy on Drug abuse prevention in schools,
  - Conduct an advocacy on reproductive health

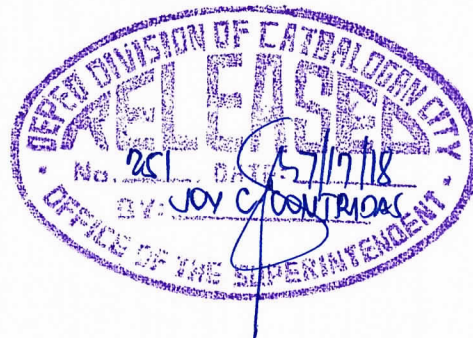


**BuNGKARAS** - Building New Generation Knowledge and Attitudes by Raising Advanced and Innovative School Leaders  
"Liderato nga maabik DepEd nga makaril" (Empowered and Innovative Leadership results to dynamic DepEd)

2<sup>nd</sup> Floor, Laohoo Bldg., Del Rosario St., Catbalogan City  
Email: [depedcatbalogancitydivision15@gmail.com](mailto:depedcatbalogancitydivision15@gmail.com)  
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Catbalogan City  
Telefax: (005) 251-3196 (055) 543 8268

- Conduct an advocacy on oral health
  - Conduct of age-appropriate health practices such as individual daily hand washing and tooth brushing activities (Tooth brushing drills), Orientation on personal hygiene including menstrual hygiene management
  - Conduct of Poster Making Contest on OK sa DepEd "All in One Health Week" program by selected students of each grade level.
5. Public and private elementary and secondary school heads of the 10 districts shall simultaneously conduct the list of suggested activities on July 23-26 2018 and shall submit a Picto-Narrative Accomplishment Report relative to the activities conducted by the schools on or before August 13, 2018 Attention: **Dr. Jonathan Andrie J. Usero, DMD, Division Dentist, Chatelaine M. Macopia, RN, Sandra C. Galitan, RN, and Sherrydale Queen H. Uy, RN.**
6. See the following attached enclosures for your references:
- A. OK sa DepEd Data Privacy Notice
  - B. SHD Form 1- Medical History DepEd
  - C. SHD Form 2
  - D. SHD Form 3
  - E. OK sa DepEd Form B
7. For school expenses incurred on this activity shall be charged against School MOOE, while for Division expenses shall be charged to OK sa DepEd allotment fund subject to the usual accounting and auditing rules and regulations.
8. For immediate dissemination and compliance of this memorandum is required.

  
**CRISTITO A. ECO, CESO VI**  
 Schools Division Superintendent



SGOD/JAJU/16718



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## **Data Privacy Notice**

The Department of Education shall engage in the collection of health / medical information for the purposes of tracking, provision of necessary health / medical interventions, and educational purposes. This information shall be processed in accordance with the provisions of the Data Privacy Act and the Data Privacy Policies of the Department.

This information shall be stored and held confidentially in accordance with the provisions of the Basic Education Act and may only be shared with other government agencies or third parties subject to Data sharing agreements and data privacy requirements for legitimate purposes only.

For inquiries, requests and concerns regarding your data privacy rights, please contact the data privacy compliance officer, team of the school, schools division office or regional office concerned.

I hereby authorize the Department of Education to use, collect, and process the information for the purposes of the above stated.

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Name and Signature of Child

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Name and Signature of Parent

### Medical History

1. Do you have any allergies?  Yes  No if Yes, please identify below.
- Medicine
  - Pollens
  - Food
  - Stinging Insects
  - Others: \_\_\_\_\_
2. Do you have any ongoing medical condition?  Yes  No If Yes, please identify below:
- Error of refraction
  - Asthma
  - Seizure
  - Heart problem
  - Anemia
  - Bleeding disorder
  - Hernia (painful bulge in the groin area)
  - Others: \_\_\_\_\_
3. Have you ever had surgery/ hospitalization?  Yes  No. if Yes, please specify details. \_\_\_\_\_
4. Does anyone in your family have the following conditions:
- Tuberculosis
  - Cancer if yes, what kind? \_\_\_\_\_
  - Stroke
  - Diabetes Mellitus
  - Hypertension
  - Depression
  - Others: \_\_\_\_\_
5. Exposure to cigarette/vape smoke at home?  Yes  No

I certify that the above information are correct.

\_\_\_\_\_  
Name & Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Learner

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: \_\_\_\_\_ Region: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Division: \_\_\_\_\_  
Month Day Year

Birthplace: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

	Kinder/ 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													
Temperature/BP													
Heart Rate/Pulse Rate/Respiratory Rate													
Height (in cm)													
Weight (in kg)													
Nutritional Status (NS) (BMI/Wt-for-Age)													
Nutritional Status (NS) (Height-for-Age)													
Vision Screening using appropriate chart													
Auditory Screening (Tuning Fork)													
Skin/ Scalp													
Eyes/Ears/Nose													
Mouth/Throat/Neck													
Lungs/Heart													
Abdomen													
Deformities													
Iron Supplementation (V or X)													
Deworming (V or X)													
Immunization (Specify what kind)													
SBFP Beneficiary (V or X)													
4Ps Beneficiary (V or X)													
Menarche (V the Start)													
Others, specify													
<b>Examined by:</b>													

**LEGEND:**

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

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









Republic of the Philippines  
**DEPARTMENT OF EDUCATION**

Region: \_\_\_\_\_  
 Division of: \_\_\_\_\_  
**DENTAL REFERRAL FORM**

Patients Name: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

Dear Dr.: \_\_\_\_\_

I am referring \_\_\_\_\_ to your office for:

<input type="checkbox"/>	Oral Prophylaxis									
<input type="checkbox"/>	Restoration	18	17	16	15	14	13	12	11	21
<input type="checkbox"/>	Extraction	47	47	46	45	44	43	42	41	31
<input type="checkbox"/>	Other Procedures:									

Note: (Example: Resto#16, Exo #46) If OUT is needed

Sincerely:  
 \_\_\_\_\_  
 School Dentist

Kindly return Dental Slip

**DENTAL TREATMENT RETURN SLIP**

Dental Procedure done:

<input type="checkbox"/>	Oral Prophylaxis	_____
<input type="checkbox"/>	Restoration	_____
<input type="checkbox"/>	Extraction	_____
<input type="checkbox"/>	Other Procedures:	_____

Signature:  
**DENTIST'S NAME:**  
 Lic. No.:





**OPLAN KALUSUGAN SA DEPED  
ACCOMPLISHMENT REPORT**  
*(To be accomplished by the School Head)*

<b>DIVISION:</b>	<b>REGION:</b>	
<b>SCHOOL:</b>	<b>SCHOOL ID:</b>	
<b>SCHOOL ADDRESS:</b>		
(Please check appropriate box) <b>Level:</b>		
<input type="checkbox"/> Elementary	<input type="checkbox"/> Central School	
<input type="checkbox"/> Junior High School	<input type="checkbox"/> Non-Central School (complete)	
<input type="checkbox"/> Senior High School	<input type="checkbox"/> Multigrade	
	<input type="checkbox"/> Primary School / Incomplete	
	<input type="checkbox"/> Integrated School	
<b>SCHOOL HEAD:</b>	<b>CONTACT NUMBER:</b>	

A. COVERAGE	Grade Level	Number of Pupils			Number of School Personnel				
		Enrolment	Actual Examined	With findings	Given interventions	Enrolment	Actual Examined	With findings	Given interventions
<b>TOTAL:</b>									

**B. ACCOMPLISHMENTS**

Use School Health Division Form 2 as basis for accomplishing this table.

1. Common Signs and Symptoms (as reported by Nurses) –			
2. Common Diseases (as diagnosed by Medical Doctors) –			
3. Common Dental Problems (as diagnosed by Dentists) –			
4. Nutritional Status			
Body Mass Index-for-Age/ Weight-for-Age	Number of Learners	Height-for-Age	Number of Learners
Severely Wasted/ Severely Underweight		Severely Stunted	
Wasted/ Underweight		Stunted	
Normal		Normal	
Overweight		Tall	
Obese			
<b>TOTAL:</b>			

**C. SUMMARY OF VOLUNTEER SERVICES**

Use OK sa DepEd Form C as basis for accomplishing this table.

Name of Organization/ Affiliation/ Institution	Number of Volunteers												No. of Learners and School Personnel		Estimated Value of Interventions Given	Other Services Rendered (if any)
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Total	Examined		

**D. DONATIONS / RESOURCES GENERATED (Add additional sheets, if needed.)**

Type of Donations	Quantity		Estimated Cost	Donor



<b>H. PROPOSED PLAN OF ACTION FOR NEXT OK sa DepEd health services</b>	
<b>I. PHOTOS (before, during and after)</b>	
Prepared by:	Date:
<i>Name and Designation</i>	
Submit completed form to the SDO by 1 <sup>st</sup> week of March.	