Republic of the Philippines
Department of Education
REGION VII – CENTRAL VISAYAS
Schools Division Office of Bohol

Office of the Schools Division Superintendent

June 9, 2026

DIVISION MEMORANDUM
No. 360, s. 2026

IMPLEMENTATION OF CONSENT FORMS PRIOR TO THE CONDUCT OF LEARNERS HEALTH ASSESSMENT AND SCREENING WITH ROUTINERY SCHOOL HEALTH COMMODITY-BASED ACTIVITIES AND SERVICES FOR S.Y. 2026-2027

To: Public Schools District Supervisors/Acting Public Schools District Supervisors
School Heads
All Teaching and Non-teaching Personnel
All other concerned

1. Pursuant to the Department of Education's commitment to safeguard the health, safety, and well-being of learners through the School Health Program, this memorandum ensures the proper **implementation of parental/guardian consent procedures prior to the conduct of Learner's Health Assessment and Screening (LHAS) and routine School Health commodity-based services for S.Y. 2026-2027**

2. The implementation shall ensure the delivery of School Health services/activities which includes:

   a. Learners' Health Assessment and Screening (LHAS):
      - Head-to-Toe Assessment
      - Oral Health Assessment
      - Universal Mental Health and Psychosocial Screening

   b. Commodity-based health services:
      - Mass Deworming activities (July 2026 and January 2027)
      - Weekly Iron Folic Acid supplementation
      - School-Based Immunization (Measles-Rubella, Tetanus-diphtheria, and Human Papillomavirus vaccines)

   c. Medical and dental referral services utilizing the Two-Way Medical and Dental Referral Slip

3. In relation to this, the **implementation of consent forms prior to the conduct of the different health activities** will ensure that parents and guardians are adequately informed and oriented with the School Health

services with appropriate referrals for Learners identified to further evaluation and management. **The school shall be responsible in the reproduction of these forms and in securing the duly accomplished and signed informed consent from parents and guardians with the observance of data privacy.**

4. Attached herewith are as follows: (a) Learners' Health Assessment and Screening (LHAS) consent form and medical history of Learners; (b) Unified Deworming Round 1 and 2 consent form; (c) Weekly Iron and Folic Acid Supplementation consent form, (d) Medical/Dental Two-way Referral Form which can also be accessed through this link:

   https://tinyurl.com/Basic-commodity-services

5. Immediate dissemination and compliance of this memorandum to all concerned is directed.

FAY C. LUAREZ, EdD, PhD, TM, CESO V
Schools Division Superintendent

SHD Form 1

Republic of the Philippines
DEPARTMENT OF EDUCATION
Region VII, Central Visayas
Division of BOHOL PROVINCE

_____
School Name/ID

SCHOOL HEALTH EXAMINATION CARD

Name: _____
Last First Middle

Date of Birth: _____ Birthplace: _____
Month / Day / Year

School ID: _____ Region: _____

Learner Reference Number (LRN): _____ Division: _____

Parent/Guardian: _____ Telephone No.: _____

Home Address: _____

_____

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.

_____ _____
Name and Signature of Child **Name and Signature of Parent**

SHD Form 1-A

Name : _____ LRN : _____

Medical History (For Learners)

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 identify below:
   _____

4. Does anyone in your family have the following conditions:
   __ Tuberculosis
   __ Cancer If yes, what kind? _____
   __ Stroke
   __ Diabetes Mellitus
   __ Hypertension
   __ Depression
   __ Other _____

5. Exposure to cigarette/vape smoke at home? _____ Yes _____ No

I certify that the above information are correct.

_____ _____
Name & Signature of Parent/Guardian Date

Republic of the Philippines
Department of Education
REGION VII – CENTRAL VISAYAS
Schools Division Office of Bohol

SULAT PAHIBALO

DIVISION: Department of Education Bohol Division
Pangalan sa Eskwelahan: _____
Petsa: _____
Pangalan sa Estudyante: _____
Pangalan sa Pinuy-anan: _____
Pangalan sa Ginikanan/Tig-atiman: _____

Minahal nga Ginikanan/Tig-atiman,

Kining eskwelahana isip usa ka pampublikong elementarya/sekondaryang eskwelahan magpahigayon sa mosunod nga mga serbisyong panglawas alang sa mga estudyante uban sa koordinasyon sa School Health Section.

- ☐ Kinatibuk-ang eksaminasyon sa panglawas ug angay nga interbensyon
- ☐ Eksaminasyon sa kahimsog sa baba ug ngipon ug angay nga interbensyon
- ☐ Pagpurga (Round 1 ug Round 2)
- ☐ Semana nga paghatag og Iron Folic Acid Supplement alang sa mga dalagitang estudyante (Babaye nga Grade 7–10)

Kining pahibalo gihatag aron ipahibalo kaninyo ang mga kalihokan nga pagahimoon sa Tuig sa Eskwela 2026–2027. Kon kamo adunay mga pangutana o nagkinahanglan og dugang nga pagpasabot bahin niini, palihug ayaw pagduhaduha sa pagkontak sa Prinsipal o Ulo sa Eskwelahan..

Daghang salamat.

Matinud-anon kaninyo

FAY C. LUAREZ EdD, Phd, TM, CESO V
Schools Division Superintendent

Kini aron pag-ila sa pagdawat sa Pahibalo nga Sulat bahin sa pagpahigayon sa mga Serbisyong Panglawas nga Nakabase sa Eskwelahan. Nabasa ug nasabtan ko ang impormasyon mahitungod sa gituyo nga mga serbisyong panglawas nga ihatag sa akong anak.

☐ Oo, tugotan ko ang akong anak nga makadawat sa **tanang serbisyong** panglawas.

☐ Oo, tugotan ko ang akong anak **apan alang lamang sa mosunod nga mga serbisyo**
_____

☐ **Dili ko tugotan** ang akong anak nga makadawat sa mga benepisyo sa serbisyong panglawas. Isulti ang hinungdan:_____

_____
Ngalan ug Pirma sa Ginikanan/Tig-atiman

2019 SHD Form 3A

Republic of the Philippines
DEPARTMENT OF EDUCATION
Region _____
Division of _____

_____
School Name/ID

MEDICAL REFERRAL FORM

To _____ Date _____
(Agency)

Address _____

This is to refer to you:

Name: _____ Age: _____ Sex: _____

Address/School: _____ Grade: _____

Chief Complaint:

_____

_____

_____

Impression: _____

Remarks: _____

_____

_____

Name and Signature

_____
Designation

Note: To be detached from upper portion and sent back to the school.

_____
Name of Institution

Medical Treatment Return Slip

Returned to _____

Name of Patient _____ Date Referred _____

Chief Complaint _____

Findings _____

Action/Recommendations _____

Date

Name & Signature

_____
Designation

2019 SHD Form 3B

Republic of the Philippines

DEPARTMENT OF EDUCATION

Region _____

Division of _____

_____

School Name/ID

DENTAL REFERRAL FORM

Patient's Name:
Age:
Phone Number:

Dear Dr.: _____

I am referring _____ to your office for:

☐ Oral Prophylaxis

☐ Restoration

☐ Extraction

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
47	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

☐ Other Procedures: _____

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

Sincerely:

_____
School Dentist

_____
Name of Institution

DENTAL TREATMENT SLIP
(Kindly return this Dental Slip)

Dental Procedure done:

☐ Oral Prophylaxis _____

☐ Restoration _____

☐ Extraction _____

☐ Other Procedures: _____

Signature:

NAME OF DENTIST:
Lic. No.: