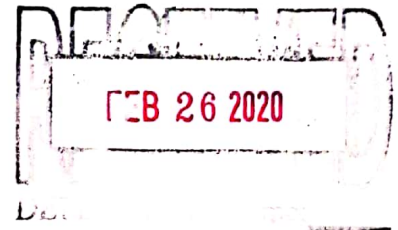




Republic of the Philippines  
**Department of Education**  
Cordillera Administrative Region  
**SCHOOLS DIVISION OFFICE OF ABRA**



Office of the Schools Division Superintendent

February 24, 2020

DIVISION MEMORANDUM

No. 044, s.2020

**ANNUAL MEDICAL EXAMINATION OF TEACHING AND NON-TEACHING  
PERSONNEL OF SDO ABRA**

To: Assistant Schools Division Superintendent  
Chief Education Supervisors, CID and SGOD  
All Division Personnel  
Public Schools District Supervisors  
All Schools Heads of Elementary and Secondary Schools  
All DepEd Elementary, Junior and Senior High School Nurses  
All Others Concerned

1. Annually, the Schools Division Office of Abra facilitates the Annual Medical Examination of Teaching and Non-Teaching Personnel to ensure that our personnel are healthy and physically fit.
2. This is to follow the rulings on Rule No. 1960 of the Department of Labor and Employment (Occupational Health Services), Administrative Order No. 042, s. 1998 (Establishment of a Medical Check-up Program for Government Personnel), Civil Service Commission Memorandum Circular No. 17, s. 1989 and DepED Memorandum 015, s. 2015.
3. In consideration of the recent trend of younger and younger populace having diseases and cardiac diseases, Personnel aged forty (40) years old and above must undergo the following laboratory exams:
  - a. Complete Blood Count (CBC)
  - b. Complete Blood Chemistry including Fasting Blood Sugar (FBS), Blood Urea Nitrogen (BUN), Blood Uric Acid (BUA), Creatinine, Cholesterol, Triglyceride, High/Low Density Lipids, and SGOT/SGPT.
  - c. Urinalysis
  - d. Other Specialized examinations as prescribed by physician.



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Accelerating and Bolstering Responsive Education that Nurtures Inspired and Outstanding LEARNERS... #ServingYOUwithaHeart





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4. For Personnel aged below forty (40) years old must undergo the following laboratory exams:
  - a. Complete Blood Count
  - b. Urinalysis
  - c. Other Specialized Examinations as prescribed by physician
5. A medical examination (SHD Form 5) form will be accomplished by a licensed Medical Practitioner. A copy of SHD Form 5 is attached for reproduction.

**GLORIA B. BUYA-AO**

Schools Division Superintendent

for the SPS:

**CHRISTOPHER C. BENIGNO**

OIC-Assistant Schools Division Superintendent

JBD/OM-ANNUALMED...



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Republic of the Philippines  
**Department of Education**  
 Cordillera Administrative Region  
 SCHOOLS DIVISION OF ABRA

**TEACHER'S HEALTH EXAMINATION RECORD**

Name: \_\_\_\_\_ Division: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Type of Work: \_\_\_\_\_ Sex: \_\_\_\_\_ Civil Status: \_\_\_\_\_

School: \_\_\_\_\_

1	Date:	Date:
	Height	Height
	Weight	Weight
2	Temperature:	Temperature:
3	Respiratory System:	Respiratory System:
	Fluorography:	Fluorography:
	Sputum Analysis:	Sputum Analysis:
4	Circulatory System:	Circulatory System:
	Blood Pressure:	Blood Pressure:
	Pulse:	Pulse:
	Sitting:                      Agility Test:	Sitting:                      Agility Test:
5	Digestive System:	Digestive System:
6	Genito-Urinary:	Genito-Urinary:
	Urinalysis, etc.	Urinalysis, etc
7	Skin:	Skin:
8	Locomotor System:	Locomotor System:
9	Nervous System:	Nervous System:
10	Eyes:	Eyes:
	Color Perception:	Color Perception:
11	Vision:	Vision:
	With glasses:              Far:              Near:	With glasses:              Far:              Near:
	Without glasses:              Far:              Near:	Without glasses:              Far:              Near:
12	Nose:	Nose:
13	Ear:	Ear:
14	Hearing:	Hearing:
	Right:                      Left:	Right:
15	Throat:	Throat:
16	Teeth and Gums:	Teeth and Gums:
17	Immunization:	Immunization:
18	Remarks	Remarks
19	Recommendation	Recommendation
20	Employee's Signature:	Employee's Signature:
	Employee's Name (Print):	Employee's Name (Print):
21	Physician's Signature:	Physician's Signature:
	Physician's Name (Print):	Physician's Name (Print):

Document Code: SDOABRA-QF-SGOD -SHS-023

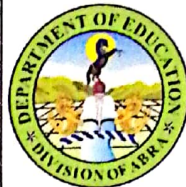
Revision: 00

Effectivity date: 02-07-2020

Name of Office:  
**SCHOOL HEALTH SECTION**



Republic of the Philippines  
Department of Education  
Cordillera Administrative Region  
**SCHOOLS DIVISION OF ABRA**  
Bangued, Abra



**LABORATORY REQUEST FORM**

**LABORATORY REQUEST FORM**

Name of Patient: _____		Birth Date: : _____ Date: _____		
Address: _____		Age: _____ Sex: _____ CS: _____		
Diagnosis: _____		School/Office: _____		
<b>HEMATOLOGY</b> <input type="checkbox"/> √CBC <input type="checkbox"/> √Platelet Count <input type="checkbox"/> Hemoglobin/Hematocrit <input type="checkbox"/> Clotting Time <input type="checkbox"/> Bleeding Time <input type="checkbox"/> RH Typing <input type="checkbox"/> ESR <input type="checkbox"/> Peripheral Blood Smear <input type="checkbox"/> Prothrombin Time <input type="checkbox"/> APTT  <b>BLOOD BANK</b> <input type="checkbox"/> Crossmatch <input type="checkbox"/> Therapeutic Bleeding	<b>SEROLOGY</b> <input type="checkbox"/> HBsAg <input type="checkbox"/> RPR/VDRL <input type="checkbox"/> HIV <input type="checkbox"/> HCV <input type="checkbox"/> Malaria RDT <input type="checkbox"/> PSA <input type="checkbox"/> H.Pylori <input type="checkbox"/> Troponin I <input type="checkbox"/> Dengue Duo <input type="checkbox"/> Typhi Dot <input type="checkbox"/> ASO Titer <input type="checkbox"/> Widal Test <input type="checkbox"/> HAV <input type="checkbox"/> Anti-HB's	<b>CLINICAL CHEMISTRY</b> <input type="checkbox"/> √FBS/RBS/CBG <input type="checkbox"/> √BUN <input type="checkbox"/> √BUA <input type="checkbox"/> √Creatinine <input type="checkbox"/> √Cholesterol <input type="checkbox"/> √Triglyceride <input type="checkbox"/> √HDL/LDL <input type="checkbox"/> √SGOT/SGPT <input type="checkbox"/> Alk. Phosphatase  <b>ELECTROLYTES</b> <input type="checkbox"/> Sodium <input type="checkbox"/> Potassium <input type="checkbox"/> Chloride <input type="checkbox"/> Calcium <input type="checkbox"/> Magnesium	<input type="checkbox"/> LDH <input type="checkbox"/> Bilirubin <input type="checkbox"/> Total Bilirubin <input type="checkbox"/> Albumin <input type="checkbox"/> Globulin <input type="checkbox"/> Total Protein <input type="checkbox"/> HBA1c <input type="checkbox"/> Lipase <input type="checkbox"/> Amylase  <b>THYROID FUNCTION TEST</b> <input type="checkbox"/> T3 <input type="checkbox"/> T4 <input type="checkbox"/> TSH	<b>CLINICAL MICROSCOPY</b> <input type="checkbox"/> √Urinalysis <input type="checkbox"/> Pregnancy Test <input type="checkbox"/> Urine Ketones <input type="checkbox"/> Urine Sugar <input type="checkbox"/> Urine Albumin  <b>PARASITOLOGY</b> <input type="checkbox"/> Fecalysis <input type="checkbox"/> Occult Blood <input type="checkbox"/> Malarial Smear  <b>MICROBIOLOGY</b> <input type="checkbox"/> Gram Stain <input type="checkbox"/> Acid Fast Stain <input type="checkbox"/> KOH
Requesting Physician: <b>APOLINAR L. TURQUEZA, MD</b> MEDICAL OFFICER III				

**RADIOLOGY REQUEST FORM**

Name of Patient: _____		Birth Date: : _____ Date: _____	
Address: _____		Age: _____ Sex: _____ CS: _____	
Diagnosis: _____		School/Office: _____	
Procedure: _____			
Requesting Physician: <b>APOLINAR L. TURQUEZA, MD</b> MEDICAL OFFICER III			

**OTHER MEDICAL PROCEDURE REQUEST FORM**

Name of Patient: _____		Birth Date: : _____ Date: _____	
Address: _____		Age: _____ Sex: _____ CS: _____	
Diagnosis: _____		School/Office: _____	
Procedure: _____			
Requesting Physician: <b>APOLINAR L. TURQUEZA, MD</b> MEDICAL OFFICER III			