



Republic of the Philippines  
**Department of Education**  
 Region VI – Western Visayas  
**SCHOOLS DIVISION OF CAPIZ**

18 MAY 2026

**DIVISION MEMORANDUM**

No. **203**, s. 2026

**CORRIGENDUM TO DIVISION MEMORANDUM NO. 177, S. 2026 TITLED ANNUAL PHYSICAL EXAMINATION OF TEACHING AND NON-TEACHING PERSONNEL**

To: Assistant Schools Division Superintendent  
 OIC-Chief Education Supervisors  
 Education Program Supervisors  
 Public Schools District Supervisors  
 Heads of Public Elementary, Secondary and Integrated Schools  
 All Others Concerned

1. In relation to Division Memorandum No. 177 s.2026 titled **Annual Physical Examination of Teaching and Non-Teaching Personnel**, this Office hereby inform the field of the change in schedule for the conduct of the said activity, to wit:

DISTRICT	FROM	TO
Dumarao	June 3, 2026	May 26, 2026
Maayon	May 26, 2026	June 3, 2026 (PM)
Mambusao East	May 13, 2026	June 5, 2026

- All other provisions of the aforementioned Memorandum remain in effect.
- Immediate dissemination of this Memorandum is desired.

  
**ROEL F. BERMEJO**  
 Schools Division Superintendent

Reference: As stated  
 Enclosure: None  
 To be indicated in the Perpetual Index  
 under the following subjects  
 ANNUAL                      PHYSICAL                      EXAMINATION



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Republic of the Philippines  
**Department of Education**  
Region VI – Western Visayas  
**SCHOOLS DIVISION OF CAPIZ**

30 APR 2026

**DIVISION MEMORANDUM**  
NO. **177** s. 2026

**ANNUAL PHYSICAL EXAMINATION OF TEACHING AND NON-TEACHING PERSONNEL**

To: Assistant Schools Division Superintendent  
OIC-Chief Education Supervisors  
Public Schools District Supervisors  
Education Program Supervisors  
Heads of Public Elementary, Secondary & Integrated Schools  
All Others Concerned

1. Pursuant to Civil Service Commission Memorandum Circular No. 33, s. 1997 (Policy on Working Conditions in the Workplace), DepEd Order No. 14, s. 2020 (Guidelines on the Required Health Standards in Basic Education Offices and Schools), and DepEd Memorandum No. 22, s. 2015 titled "Annual Physical Examination of DepEd Employees (Teaching and Non-Teaching Personnel)", DepEd teaching and non-teaching personnel are hereby requested to undergo voluntary annual physical examination.
2. In line with this, this Office will conduct the Annual Physical Examination for all willing teaching and non-teaching personnel with or without laboratory results from **May 4, 2026 to June 5, 2026**.
3. This activity aims to ensure that personnel are physically fit to effectively perform their assigned roles and responsibilities, thereby delivering quality, healthy, and safe services as public servants.
4. Attached are enclosure No.1 "Schedule of Annual Physical Examination Per District" and the annual physical examination forms for your reference and can be accessed through this link <https://tinyurl.com/SHNUforms2026>
5. Travel expenses relative to the conduct of this activity are chargeable against Division MOOE subject to the usual auditing rules and regulations.
6. For any questions/clarification, you may contact Dionirose L. Duron, MD, Medical Officer III at mobile number 09171186511.
7. Immediate dissemination and compliance of this Memorandum are desired.

  
**ROEL F. BERMEJO**  
Schools Division Superintendent

Encl: As stated  
Reference: As stated  
To be indicated in the Perpetual Index  
under the following subjects:  
Annual                      Physical                      Examination



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Republic of the Philippines  
**Department of Education**  
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**SCHOOLS DIVISION OF CAPIZ**

Enclosure No. 1 to Division Memorandum No. **177**, s. 2026

**Schedule of Annual Physical Examination Per District**

<b>District</b>	<b>Schedule</b>
Ivisan	May 6, 2026 – Morning
Sapian	May 6, 2026 - Afternoon
Sigma	May 7, 2026
Panay	May 11, 2026
Mambusao East	May 12, 2026
Mambusao West	May 13, 2026
Jamindan	May 14, 2026
Tapaz East	May 18, 2026
Tapaz West	May 19, 2026
Dao	May 20, 2026
Panitan	May 21, 2026
Pres. Roxas	May 25, 2026
Maayon	May 26, 2026
Pontevedra	May 28, 2026
Pilar	June 1, 2026
Dumalag	June 2, 2026
Dumarao	June 3, 2026
Cuartero	June 4, 2026



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DIVISION OF CAPIZ

Name: _____					Age: _____	Sex: _____
Prefix	Last Name	First Name	Middle Name	Suffix		
Address: _____						
No.	Street	Barangay		City/Municipality	Province	
Birth date:	Birth place:	Blood type:	Religion:	Nationality: _____ Indigenous Group: Yes No		
Civil Status: <input type="checkbox"/> Co-habitation <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Separated <input type="checkbox"/> Annulled		Educ. Attainment: <input type="checkbox"/> Elem <input type="checkbox"/> HS <input type="checkbox"/> College <input type="checkbox"/> Post Grad <input type="checkbox"/> Vocational <input type="checkbox"/> No form of Educ. <input type="checkbox"/> Not applicable		Employment Status: <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed Nature of work: _____		
Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Passive Smoker    How long? _____    Willing to Stop? <input type="checkbox"/> Yes <input type="checkbox"/> No    Stopped: <input type="checkbox"/> > a year <input type="checkbox"/> < a year						
Alcohol Intake: <input type="checkbox"/> Never Consumed <input type="checkbox"/> Yes, Drinks Alcohol    Excessive intake in the past month: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Physical Activity: Does at least 2 1/2 hours a week of moderate-intensity physical activity <input type="checkbox"/> Yes <input type="checkbox"/> No						
Family History: Does patient have 1 <sup>st</sup> degree relative with: <input type="checkbox"/> Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Heart attack <input type="checkbox"/> Kidney stone <input type="checkbox"/> Diabetes						
Mother's first Name		Middle Name	Last Name	Birthdate		
<b>- CONSENT FOR PARTICIPATION TO PHIE</b>						
1. I hereby give my full consent and permission to this facility to gather send and transmit pertinent data or information (with appropriate safety measures to protect the privacy and security of my well being, health information and other rights under laws governing data privacy, security and related issuances? until it is revoked by myself or my duly authorized representative.						
2. I am made aware that I can cancel my consent at any time without giving reasons and without concerning any disadvantage for my medical treatment services.						
I Certify that I have been made to understand my rights in language and manner understandable to me by a representative of the facility/health care provider and that the health data or information is true and complete to the best of my knowledge.						
Signed this _____ day of _____, 202____.    Time: _____						
_____ Signature Over Printed Name of Patient/Representative Mobile/Landline No.: _____				_____ Signature Over Printed Name of Health Provider		
<b>Pertinent Health Information, Intervention, and Procedures</b>						
<b>O:</b> WT: _____ kg    HT: _____ cm RR: _____ Temp: _____    Rechecked: _____  <b>Heart/Pulse Rate:</b> Regular rhythm: <input type="checkbox"/> Yes <input type="checkbox"/> No Normal rate: <input type="checkbox"/> Yes <input type="checkbox"/> No  BP: _____ / _____ (Rechecked): _____ / _____ BMI: _____    BMI Category: _____ Risk prediction: _____ Waist circumference _____ cm Central adiposity: <input type="checkbox"/> Yes <input type="checkbox"/> No Obesity: <input type="checkbox"/> Yes <input type="checkbox"/> No  Assessed by: _____ Date: _____    Time: _____				<b>S:</b>  <b>A:</b>  <b>P:</b>		
<b>Dionirose L. Duron, MD.</b> Medical Officer III Lic. No. 0144542						

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
*Last Name First Name Middle Name*

Office/School: \_\_\_\_\_ Designation: \_\_\_\_\_

## CONSULTATION RECORDS

Wt: \_\_\_\_\_ Ht: \_\_\_\_\_  
Temp: \_\_\_\_\_  
CR: \_\_\_\_\_ RR: \_\_\_\_\_  
BP: \_\_\_\_\_ Rechecked: \_\_\_\_\_

S:

A:

P:

Assessed by: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

Maintenance Meds:

Chief Complaint:

\_\_\_\_\_  
**Dionirose L. Duron, MD.**  
Medical Officer III  
License No: 0144542

Wt: \_\_\_\_\_ Ht: \_\_\_\_\_  
Temp: \_\_\_\_\_  
CR: \_\_\_\_\_ RR: \_\_\_\_\_  
BP: \_\_\_\_\_ Rechecked: \_\_\_\_\_

S:

A:

P:

Assessed by: \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

Maintenance Meds:

Chief Complaint:

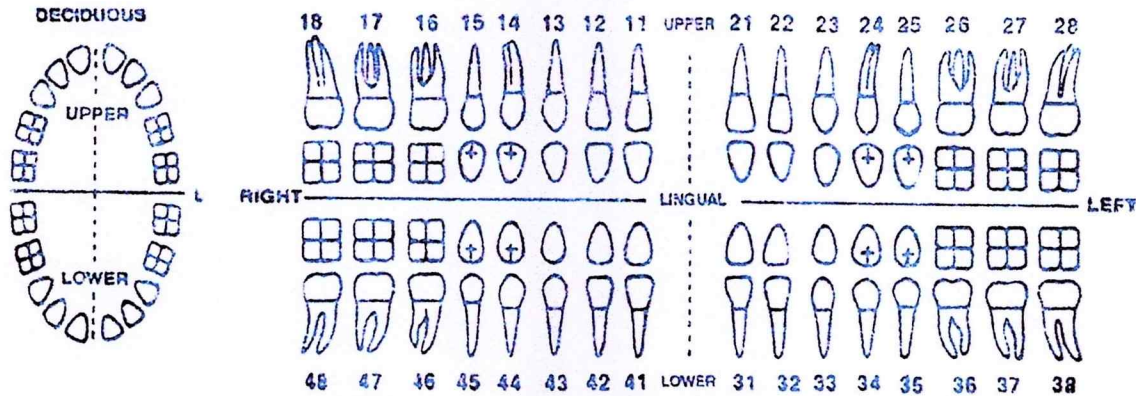
\_\_\_\_\_  
**Dionirose L. Duron, MD.**  
Medical Officer III  
License No: 0144542



NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ B-DAY \_\_\_\_\_ AGE \_\_\_\_\_ REFERRED BY \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_



PRESENT ORAL COMPLAINT \_\_\_\_\_

MEDICAL HISTORY: \_\_\_\_\_

GENERAL HEALTH \_\_\_\_\_

HEADACHES \_\_\_\_\_ SINUS TROUBLE \_\_\_\_\_

ALLERGIES \_\_\_\_\_ FREQ. COLDS \_\_\_\_\_

BLEEDING OF GUMS \_\_\_\_\_ DIABETES \_\_\_\_\_

HEART - B.P. \_\_\_\_\_ SELF-MEDICATION \_\_\_\_\_

FAMILY HISTORY \_\_\_\_\_

CLINICAL EXAMINATION \_\_\_\_\_

FACE AND LIPS \_\_\_\_\_ CHEEKS \_\_\_\_\_

TONGUE \_\_\_\_\_ PALATE \_\_\_\_\_ OROPHARYNX \_\_\_\_\_

GINGIVAE: SPONGY \_\_\_\_\_ RETRACTED \_\_\_\_\_ BLEEDING \_\_\_\_\_

MISSING TEETH \_\_\_\_\_ MALOCCLUSION \_\_\_\_\_

PREVIOUS DENTAL CARE \_\_\_\_\_

REMARKS: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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