



Republic of the Philippines
Department of Education
NEGROS ISLAND REGION
SCHOOLS DIVISION OF ESCALANTE CITY



May 25, 2026

DIVISION MEMORANDUM

No. 207, s. 2026

COMPLIANCE OF SCHOOL-BASED TEACHING PERSONNEL WITH ANNUAL PHYSICAL EXAMINATION (APE) LABORATORY REQUIREMENTS

To: OIC-Assistant Schools Division Superintendent
Education Program Supervisors
School Heads
Administrative Officers (AOs)
All School-Based Teaching Personnel
All Others Concerned

1. In accordance with DepEd Memorandum No. 22, s. 2015 Annual Physical Examination of DepEd Employees – Teaching and Non-Teaching Personnel and Civil Service Commission Memorandum Circular No. 17, s. 1989, all personnel are hereby directed to comply with the submission of the required laboratories for the Annual Physical Examination (APE) on or before **June 30, 2026**.
2. Personnel may choose their preferred laboratory or health care provider in the conduct of the required diagnostic tests for the annual physical examination and are advised to utilize their medical allowance, respective Health Maintenance Organization (HMO), or their designated PhilHealth Konsulta/Yakap provider, whenever applicable.
3. The required laboratory and diagnostic examinations for the Annual PE are the following:
 - a. complete blood count (CBC) with platelet count
 - b. urinalysis
 - c. routine stool examination
 - d. chest x-ray PA
4. Suggested laboratory tests for personnel with known comorbidities:
 - a. Diabetic – include Fasting Blood Sugar (8-10 hours of fasting)
 - b. Hypertensive – include Lipid Profile (10-12 hours of fasting)
5. All laboratory results must have a validity of three (3) months from the date of examination at the time of submission.
6. In addition to the laboratory requirements, all teaching personnel are requested to accomplish the enclosed Medical History Form, which is likewise available for download through the link tinyurl.com/MedicalHistoryFormAPE, and attach all laboratory examination results upon submission.
7. The respective Administrative Officer IIs (AO IIs) of each school are requested to facilitate the collection, verification, and consolidation of all submitted documents and ensure that laboratory results and duly accomplished Medical History Forms are complete, properly organized in one folder, and arranged in alphabetical order prior to



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submission to the School Health and Nutrition (SHN) Unit Clinic located at Escalante City Central Elementary School.

8. Personnel with laboratory findings requiring further health assessment or medical follow-up shall be contacted directly by the School Health and Nutrition (SHN) Unit for appointment scheduling.

9. Should personnel opt to have their laboratory results interpreted by their own private physician, they are required to submit a medical certificate or medical clearance as supporting documentation, certifying that the results were reviewed and that necessary medical advice, treatment, or interventions were provided, if applicable.

10. All medical information and laboratory findings submitted shall be treated with utmost confidentiality and shall be utilized solely for health monitoring, wellness interventions, and appropriate health referral purposes.

11. Immediate dissemination of and compliance with this Memorandum are desired.


PETER J. GALIMBA

Assistant Schools Division Superintendent
OIC- Office of the Schools Division Superintendent

M.K. ABELLA/ SGOD/ SHN
Reference : As stated
Enclosure : None
To be indicated in the Perpetual Index

ANNUAL PHYSICAL EXAMINATION
TEACHING PERSONNEL



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Enclosure No. 1 of DM No. 207, s. 2026



MEDICAL HISTORY FORM
 Completely fill in the required information

Patient Information				
Name		DOB	Gender: M/ F/Other: _____ Messenger Name:	
Address			Phone:	
Emergency Contact				
Name:		Relationship:	Phone:	
Insurance/ HMO Information				
Insurance Provider			Policy number	
Personal history (check all that apply)				
No known medical conditions		Heart Attack / Heart Disease		
Allergies (Drug, Food, Environmental)		High Blood Pressure (Hypertension)		
Anemia		High Cholesterol		
Anxiety		HIV/AIDS		
Arthritis		Kidney Disease / Kidney Stones		
Asthma		Liver Disease / Hepatitis		
Blood transfusion		Migraines		
Cancer (Specify: _____)		Osteoporosis		
Congestive heart failure		Stroke		
COPD / Emphysema		Substance Abuse (Alcohol / Drugs)		
Depression		Thyroid Disease (Hypo / Hyper)		
Diabetes (Type 1 / Type 2)		Tuberculosis		
Epilepsy / Seizures		Ulcers		
GERD (Acid Reflux)				
Glaucoma				
Gout				
Other medical issues:				
Treatments/Medications				
Name(s)	Dosage(s)	Frequency	Purpose	Notes
Surgeries/Procedures (with dates):			Allergies	
Family history (check all that apply)				
No known family history of medical conditions		Stroke		
Cancer		Thyroid Disease		
Diabetes		Kidney Disease		
Heart Disease		Mental Health Conditions (Depression, Anxiety, etc.)		
High Blood Pressure		Autoimmune Diseases		
High Cholesterol		Other: _____		





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Social history		
Factor	Circle one	Most recent date
Tobacco Use	Never / Former / Current	
Alcohol Use	Occasional / Moderate / Heavy	
Recreational Drugs	No / Yes (Specify)	
Exercise Routine	[] Times per week	
Review of Systems (<i>Check any symptoms that you are experiencing</i>)		
<i>General</i>	<i>Eyes</i>	<i>Cardiovascular</i>
Fatigue Fever or chills Unexplained weight loss/gain	Vision changes (blurry, double vision) Hearing loss or ringing Sore throat / Hoarseness	Chest pain or tightness Palpitations (fast or irregular heartbeat) Swelling in legs or feet
<i>Respiratory</i>	<i>Gastrointestinal</i>	<i>Neurological</i>
Shortness of breath Chronic cough Wheezing	Abdominal pain Nausea or vomiting Diarrhea or constipation	Headaches or migraines Dizziness or lightheadedness Numbness or tingling
<i>Musculoskeletal</i>	<i>Psychiatric</i>	<i>Other (please list)</i>
Joint pain or stiffness Muscle weakness Back pain	Depression or feeling down Anxiety or panic attacks Sleep disturbances (insomnia, nightmares)	
Additional notes		
Patient name		Date
Patient signature		Date