



Republic of the Philippines
Department of Education
REGION I
SCHOOLS DIVISION OF VIGAN CITY

DIVISION MEMORANDUM

No. 598, s.2025

**CONDUCT OF MEDICAL ASSESMENT OF THE PARTICIPANTS TO
 SY 2025-2026 YEAR-ROUND SPORTS TRAINING**

To: Assistant Schools Division Superintendent
 Chief Education Supervisor (SGOD & CID)
 Public Elementary and Secondary School Heads
 All Others Concerned

1. In connection with Division Memorandum No. 558, s. 2025 titled: Conduct of SY 2025-2026 Year-round Sports Training, this office announces the conduct Medical Assessment for Athletes and coaches from September 1 to October 7, 2025 at the School Health and Nutrition Section (SHNS) Clinic.
2. Moreover, coaches and athletes are advised to bring a duly accomplished Medical History Form prior to the conduct of medical assessment.
3. Enclosed is the schedule of medical assessment and medical history form for reference.
4. Immediate and wide dissemination of this memorandum is earnestly desired.


VILMA D. EDA, CESO V
 Schools Division Superintendent,

Encls.: None

Reference: Division Memorandum No. 558, s. 2025

To be indicated in the Perpetual Index

Under the following subjects:

SPORTS TRAINING MEDICAL ASSESSMENT
 SGOD/DSO



Address: Mena Crisologo St. corner Rivero St., Brgy. IX, Vigan City, Ilocos Sur
 Telephone No: (077) 722-20-23 / (077) 632-05-33
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Enclosure No. 1 to Division Memorandum No. _____, s. 2025

SCHEDULE OF MEDICAL ASSESSMENT

SCHEDULE	SPORTS EVENT
September 1, 2025	
9:00 AM – 12:00 NN	Boxing & Pencak Silat
1:30 PM - 4:30 PM	Taekwondo, Wrestling & Wushu
September 2, 2025	
9:00 AM – 12: 00 NN	Arnis
1:30 PM – 4:30 PM	
September 3, 2025	
9:00 AM – 12:00 NN	Athletics
1:30 PM – 4:30 PM	
September 4, 2025	
9:00 AM – 12: 00 NN	Athletics
1:30 PM – 4:30 PM	
September 5, 2025	
9:00 AM – 12: 00 NN	Athletics
1:30 PM – 4:30 PM	Futsal Basketball 3x3 (Girls)
September 8, 2025	
9:00 AM – 12: 00 NN	Gymnastics (Girls)
1:30 PM – 4:30 PM	
September 10, 2025	
9:00 AM – 12: 00 NN	Gymnastics (Boys)
1:30 PM – 4:30 PM	Lawn Tennis Table Tennis
September 15, 2025	
9:00 AM – 12:00 NN	Football
1:30 PM – 4:30 PM	
September 16, 2025	
9:00 AM – 12: 00 NN	Basketball
1:30 PM - 4:30 PM	
September 22, 2025	
9:00 AM – 12:00 NN	Swimming
1:30 PM – 4:30 PM	Sepak Takraw
September 23, 2025	
9:00 AM – 12: 00 NN	Dance Sports
1:30 PM – 4:30 PM	Baseball
September 24, 2025	
9:00 AM – 12:00 NN	Volleyball (Boys)
1:30 PM – 4:30 PM	
September 25, 2025	
9:00 AM – 12: 00 NN	Volleyball (Girls)
1:30 PM – 4:30 PM	
September 26, 2025	
9:00 AM – 12:00 NN	Badminton (boys)
1:30 PM – 4:30 PM	
October 7, 2025	
9:00 AM – 12:00 NN	Chess



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Enclosure No. 2 to Division Memorandum No. _____, s. 2025

MEDICAL HISTORY FORM

I. GENERAL DATA

Name: _____ Date of Assessment: _____

Date of Birth: _____ Age: _____ Sex: _____
 Present Address: _____

(House/Bldg. No. Street Address) (Barangay) (Town)
 Name of School: _____
 Grade level/Section: _____

II. FAMILY HISTORY

A. Parents

Name of Father: _____ Age: ____ Occupation: _____

Contact Number: _____

Mother's Name (Maiden): _____ Age: ____ Occupation: _____

Contact Number: _____

B. Siblings: (In Birth Order)

Name	Age & Sex	Name	Age & Sex
1.		4.	
2.		5.	
3.		6.	

C. Familial Illness (please ✓ check appropriate box)

1. Tuberculosis		5. Allergy (Specify: _____)	
2. Diabetes Mellitus		6. Hypertension	
3. Cancer		7. Others:	
4. Bronchial Asthma			

III. PERSONAL HISTORY

Age of mother during pregnancy: _____

Manner of Patient's delivery: ____ NSD ____ CS Indication: _____

Place of Birth: _____ Birth Weight: _____

Newborn Screening Result: _____

A. Past Illness: Date/Age

Date/Age			
Varicella (Chicken Pox)		Pneumonia	



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Measles		Dengue	
Mumps		Hand, Foot and Mouth Disease	
Bronchial Asthma		Seizure	
Primary Complex(PTB)		Others: (Please Specify)	
Allergy			

B. Previous Hospitalization/Surgery (Include illness, date of confinement and name of hospital)

C. Present Illness: Include date when signs and symptoms first appeared, over-the-counter medicines given and consultation to Physician sought

IV. ENVIRONMENTAL HISTORY

A. Exposures: (✓ if Yes or No)

Cigarettes ___ Yes ___ No From who? _____, Date exposed _____

Vape ___ Yes ___ No From who? _____, Date exposed _____

Environmental Pollutants ___ Yes ___ No, Date exposed _____

Specify pollutant: _____

B. Garbage Disposal: (✓ check)

___ Collected ___ Compost Pit ___ Burned

C. Water Source: (indicate)

Drinking _____

Washing _____

V. IMMUNIZATIONS:

Vaccines	Date	Date	Date	Date	Date
BCG					
Hepa B					
DPT					
IPV/OPV					
PCV					
Rota Vaccine					
Influenza					
Measles					
Varicella					



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Japanese Encephalitis					
MMR					
Hepa					
HPV					
COVID-19 V					
Others <i>(Specify)</i>					

VI. SUPPLEMENTATIONS

Date Received

Iron Supplement
 Vitamin A (200,000 iu)
 Albendazole 400 mg
 Mebendazole 500mg

Accomplished by:

 Signature over Printed Name of Parent/Guardian
 Contact Number:



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