



Republic of the Philippines  
**Department of Education**  
Region X  
**SCHOOLS DIVISION OF TANGUB CITY**



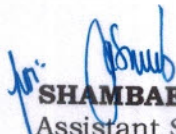

July 28, 2023

**DIVISION MEMORANDUM**  
No. 236, s. 2023

**CHANGES TO DIVISION MEMORANDUM No. 207 s. 2023**  
**ORIENTATION-WORKSHOP ON ADOLESCENT REPRODUCTIVE**  
**HEALTH PROGRAM - ARH (OK sa DepED PROGRAM)**

To: Public Schools District In-Charge  
School Health and Nutrition  
Elementary and Secondary School Heads  
School Clinic Teacher  
All Others Concerned  
This Division

1. In regard to Division Memorandum No. 207, s. 2023 dated June 26, 2023 on Orientation-Workshop on Adolescent Reproductive Health Program (OK sa DepEd Program) scheduled on August 15, 2023, the activity has been postponed indefinitely until further notice.
2. All other provisions in the said memorandum shall remain the same.
3. Immediate and wide dissemination of this memorandum is desired.

  
**SHAMBAEH A. ABANTAS-USMAN, PhD, CESE**  
Assistant Schools Division Superintendent  
OIC-Office of the Schools Division Superintendent 



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**CS FORM 86**

(Annual Physical Examination)

Date: \_\_\_\_\_

**HEALTH EXAMINATION RECORD**

**A. GENERAL INFORMATION**

Name: \_\_\_\_\_ Department: \_\_\_\_\_  
 Place of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Civil Status: \_\_\_\_\_  
 District: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
 School: \_\_\_\_\_ Years in Service: \_\_\_\_\_

**B. HEALTH STATUS:**

Height (Cm.) \_\_\_\_\_ Weight (kg.) \_\_\_\_\_  
 Temperature: \_\_\_\_\_

**Respiratory System:**

Respiratory Rate: \_\_\_\_\_ Pulse Rate: \_\_\_\_\_  
 Throat: \_\_\_\_\_ Tongue: \_\_\_\_\_  
 Ear: \_\_\_\_\_ Nose: \_\_\_\_\_  
 Hearing: Right Ear: \_\_\_\_\_ Left Ear: \_\_\_\_\_  
 Chest X-ray: \_\_\_\_\_ Sputum: \_\_\_\_\_

**Circulatory System:**

Blood Pressure: Systole: \_\_\_\_\_ Diastole: \_\_\_\_\_  
 Heart Rate: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
 CBC: \_\_\_\_\_

**Digestive System:**

Mouth: \_\_\_\_\_ Teeth & Gums: \_\_\_\_\_

**Reproductive System:**

Urinalysis: \_\_\_\_\_ Skin: \_\_\_\_\_

**Nervous System:**

Eye Conjunctiva: \_\_\_\_\_ Color Perception: \_\_\_\_\_  
 Locomotor: \_\_\_\_\_  
 Vision: Without Eyeglasses: \_\_\_\_\_ With Eyeglasses: \_\_\_\_\_

**Immunization:** \_\_\_\_\_

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

**RECOMMENDATION:** \_\_\_\_\_

**Date:** \_\_\_\_\_

\_\_\_\_\_  
 Physician/ Medical Officer  
 (Signature over Printed Name)  
 License No. \_\_\_\_\_  
 PTR: \_\_\_\_\_



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