

**OPLAN KALUSUGAN SA DEPED  
ACCOMPLISHMENT REPORT**  
(To be accomplished by the School Head)

<b>DIVISION:</b>	<b>REGION:</b>
<b>SCHOOL:</b>	<b>SCHOOL ID:</b>
<b>SCHOOL ADDRESS:</b>	
(Please check appropriate box)	
<b>Level:</b> <input type="checkbox"/> Elementary <input type="checkbox"/> Junior High School <input type="checkbox"/> Senior High School	<b>Type of School:</b> <input type="checkbox"/> Central School <input type="checkbox"/> Non-Central School (complete) <input type="checkbox"/> Multigrade <input type="checkbox"/> Primary School / Incomplete <input type="checkbox"/> Integrated School
<b>SCHOOL HEAD:</b>	<b>CONTACT NUMBER:</b>

A. COVERAGE								
Grade Level	Number of Pupils				Number of School Personnel			
	Enrolment	Actual Examined	With findings	Given interventions	Enrolment	Actual Examined	With findings	Given interventions
<b>TOTAL:</b>								

**B. ACCOMPLISHMENTS**  
Use School Health Division Form 2 as basis for accomplishing this table.

1. Common Signs and Symptoms (as reported by Nurses) –

2. Common Diseases (as diagnosed by Medical Doctors) –

3. Common Dental Problems (as diagnosed by Dentists) –

4. Nutritional Status

Body Mass Index-for-Age/ Weight-for-Age	Number of Learners	Height-for-Age	Number of Learners
Severely Wasted/ Severely Underweight		Severely Stunted	
Wasted/ Underweight		Stunted	
Normal		Normal	
Overweight		Tall	
Obese			
<b>TOTAL:</b>			

**C. SUMMARY OF VOLUNTEER SERVICES**  
 Use OK sa DepEd Form C as basis for accomplishing this table.

Name of Organization/ Affiliation/ Institution	Number of Volunteers														No. of Learners and School Personnel		Estimated Value of Interventions Given	Other Services Rendered (if any)	
	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Total	Examined	Given Intervention				

**D. DONATIONS / RESOURCES GENERATED (Add additional sheets, if needed.)**

Type of Donations	Quantity	Estimated Cost	Donor

**E. SIGNIFICANT EVENTS OF SBFP, NDEP, ARH, WINS, AND OTHER HEALTH AND NUTRITION PROGRAMS / EXPERIENCES / GOOD PRACTICES**

(Use separate sheets, if needed)

What happened?	Who were involved?	When?	Outcome: What is/are its important contribution to the Ok sa DepEd Program of the school?

**F. LESSONS LEARNED**

**G. SUGGESTIONS TO STRENGTHEN OK sa DepEd Program (include support needed from Central, Region, and Division Office that can increase the impact of OK sa DepEd Program in your school.)**

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**H. PROPOSED PLAN OF ACTION FOR NEXT OK sa DepEd health services**

**I. PHOTOS (before, during and after)**

Prepared by:

Date:

*Name and Designation*

Submit completed form to the SDO by 1<sup>st</sup> week of March.

REPUBLIC OF THE PHILIPPINES  
DEPARTMENT OF EDUCATION  
BUREAU OF LEARNER SUPPORT SERVICES - SCHOOL HEALTH DIVISION  
Pasig City

**SCHOOL HEALTH EXAMINATION CARD**

Name: _____	School ID: _____
Last                      First                      Middle	
LRN: _____	
Date of Birth: _____	Region: _____
Month                      Day                      Year	
Birthplace: _____	Division: _____
Parent/Guardian: _____	Telephone No.: _____
Address: _____	

	Kindergarten/SPED	Grade 1/SPED	Grade 2/SPED	Grade 3/SPED	Grade 4/SPED	Grade 5/SPED	Grade 6/SPED	Grade 7/SPED	Grade 8/SPED	Grade 9/SPED	Grade 10/SPED	Grade 11/SPED	Grade 12/SPED
	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings	Findings
Date of Examination													
Temperature/BP													
Heart Rate/Pulse Rate/Respiratory Rate													
Height (in cm)													
Weight (in kg)													
Nutritional Status (NS) (BMI/Wt-for-Age)													
Nutritional Status (NS) (Height-for-Age)													
Vision Screening using appropriate chart													
Auditory Screening (Tuning Fork)													
Skin/ Scalp													
Eyes/Ears/Nose													
Mouth/Throat/Neck													
Lungs/Heart													
Abdomen													
Deformities													
Iron Supplementation (✓ or X)													
Deworming (✓ or X)													
Immunization (Specify what kind)													
SBFP Beneficiary (✓ or X)													
4Ps Beneficiary (✓ or X)													
Menarche (✓ the Start)													
Others, specify													
Examined by:													

LEGEND:

NS	Vision/ Auditory Screening	Skin/Scalp	Eye/Ear/Nose	Mouth/Neck/Throat	Lungs/Heart	Abdomen	Deformities
a. Normal Weight	a. Passed	a. Normal	a. Normal	a. Normal	a. Normal	a. Normal	a. Acquired
b. Wasted/ Underweight	b. Failed	b. Presence of Lice	b. Stye	b. Enlarged tonsils	b. Rales	b. Distended	b. Congenital (Specify)
c. Severely Wasted/Underwt		c. Redness of Skin	c. Eye Redness	c. Presence of lesions	d. Wheeze	c. Abdominal Pain	
d. Overweight		d. White Spots	d. Ocular Misalignment	d. Inflamed pharynx	e. Murmur	d. Tenderness	
e. Obese		e. Flaky Skin	E. Pale Conjunctiva	e. Enlarged lymphnodes	h. Irregular heart rate	e. Dysmenorrhea	
f. Normal Height		f. Impetigo/boil	f. Ear discharge	f. Others, specify	i. Others, specify	f. Others, Specify	
g. Stunted		g. Hematoma	g. Impacted cerumen				
h. Severely Stunted		h. Bruises/ Injuries	h. Mucus discharge				
i. Tall		i. Itchiness	i. Nose Bleeding (Epistaxis)				
		j. Skin Lesions	j. Eye discharge				
		k. Acne/Pimple	k. Matted Eyelashes				
			l. Others, specify				

Note: Use Letter to record ailments and Place X if not examined

**INTERVENTION/TREATMENT RECORD**

Date	Chief Complaint	Intervention/Treatment Done	Remarks	Attended by (Name/Position)

**SCHOOL ORAL HEALTH EXAMINATION CARD**

KINDER S.Y. \_\_\_\_\_

RIGHT										55	54	53	52	51	61	62	63	64	65	LEFT																		
TEMPORARY TEETH										○	○		◇	◇	◇	◇			○	○																		
PERMANENT TEETH										18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28													
○										○	○	○	○	○		◇	◇	◇	◇			○	○	○	○													
○										○	○	○	○	○		◇	◇	◇	◇			○	○	○	○													
TEMPORARY TEETH										○	○		◇	◇	◇				○	○																		
RIGHT										85	84	83	82	81	71	72	73	74	75	LEFT																		

GRADE 1 S.Y. \_\_\_\_\_

RIGHT										55	54	53	52	51	61	62	63	64	65	LEFT																				
TEMPORARY TEETH										○	○	◇	◇	◇	◇	◇			○	○																				
PERMANENT TEETH										18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28															
○										○	○	○	○	○		◇	◇	◇	◇			○	○	○	○															
○										○	○	○	○	○		◇	◇	◇	◇			○	○	○	○															
TEMPORARY TEETH										○	○		◇	◇	◇				○	○																				
RIGHT										85	84	83	82	81	71	72	73	74	75	LEFT																				

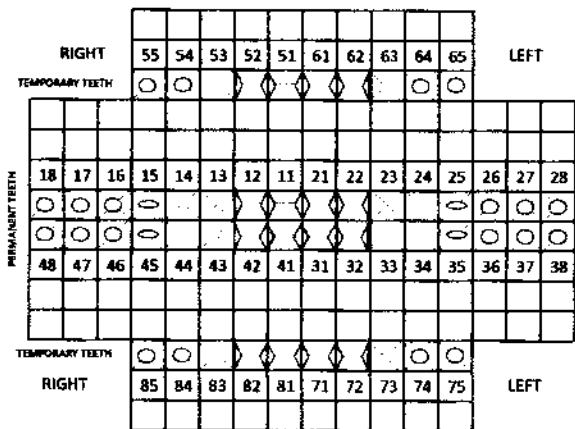
GRADE 2 S.Y. \_\_\_\_\_

RIGHT										55	54	53	52	51	61	62	63	64	65	LEFT																				
TEMPORARY TEETH										○	○		◇	◇	◇	◇			○	○																				
PERMANENT TEETH										18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28															
○										○	○	○	○	○		◇	◇	◇	◇			○	○	○	○															
○										○	○	○	○	○		◇	◇	◇	◇			○	○	○	○															
TEMPORARY TEETH										○	○		◇	◇	◇				○	○																				
RIGHT										85	84	83	82	81	71	72	73	74	75	LEFT																				

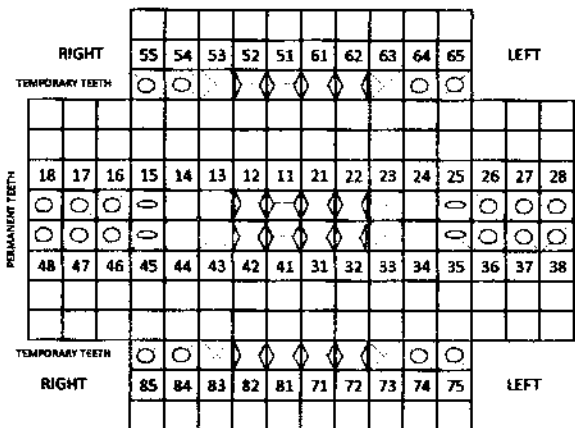
GRADE 3 S.Y. \_\_\_\_\_

RIGHT										55	54	53	52	51	61	62	63	64	65	LEFT																				
TEMPORARY TEETH										○	○		◇	◇	◇	◇			○	○																				
PERMANENT TEETH										18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28															
○										○	○	○	○	○		◇	◇	◇	◇			○	○	○	○															
○										○	○	○	○	○		◇	◇	◇	◇			○	○	○	○															
TEMPORARY TEETH										○	○		◇	◇	◇				○	○																				
RIGHT										85	84	83	82	81	71	72	73	74	75	LEFT																				

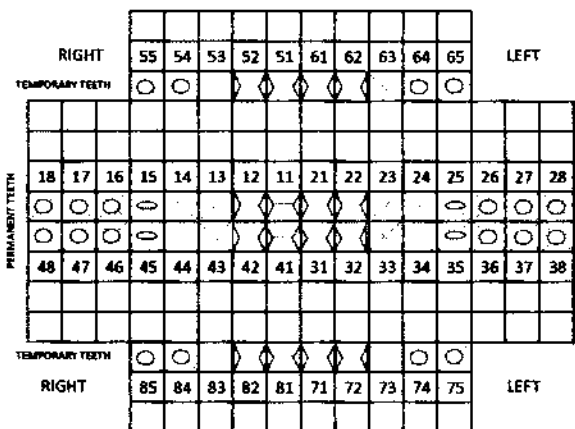
**GRADE 4**                    S.Y. \_\_\_\_\_



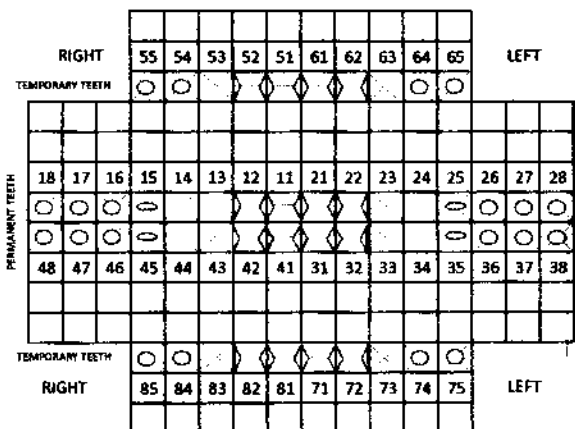
**GRADE 6**                    S.Y. \_\_\_\_\_



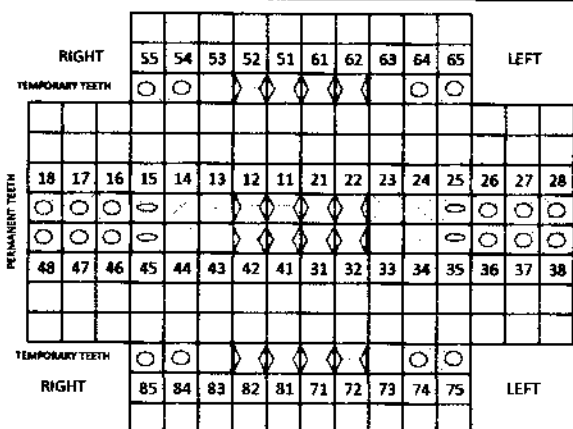
**GRADE 8**                    S.Y. \_\_\_\_\_



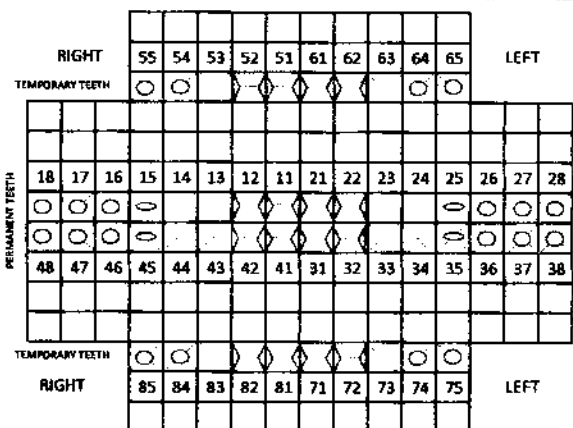
**GRADE 10**                  S.Y. \_\_\_\_\_



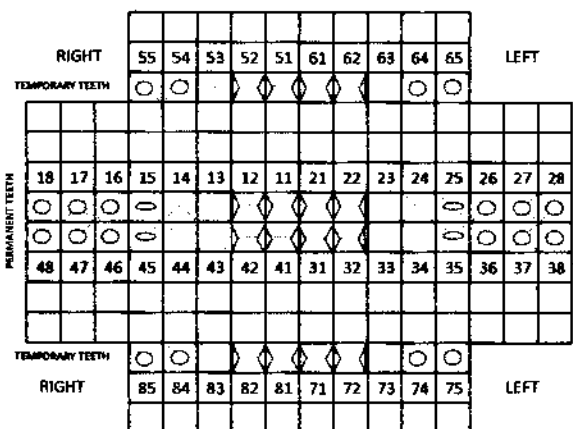
**GRADE 5**                    S.Y. \_\_\_\_\_



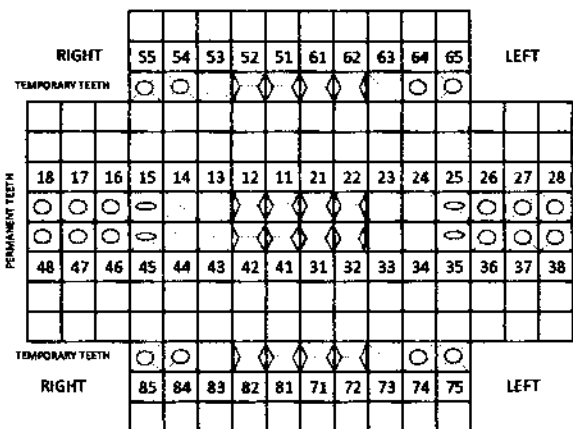
**GRADE 7**                    S.Y. \_\_\_\_\_



**GRADE 9**                    S.Y. \_\_\_\_\_



**GRADE 11**                  S.Y. \_\_\_\_\_





GRADE 12

S.Y. \_\_\_\_\_

**ORAL HEALTH CONDITION**

RIGHT											LEFT									
TEMPORARY TEETH											TEMPORARY TEETH									
PERMANENT TEETH											PERMANENT TEETH									
RIGHT											LEFT									

	Kinder	1/	2/	3/	4/	5/	6/	12
Gingivitis								
Periodontal Disease								
Malocclusion								
Supernumerary teeth								
Retained deciduous teeth								
Decubital ulcer								
Calculus								
Cleft lip / palate								
Root fragment								
Fluorosis								
Others, Specify								

**TEMPORARY TEETH**

Index d.f.t.	dft index						
No. T / decayed	Kinder	1	2	3	4	5	6
No. T / filled							
Total d.f.t.							
For Extraction							
For Filling							
Total Sound teeth							

**PERMANENT TEETH**

Index D.M.F.T.	D.M.F.T. index							
No. T / decayed	Kinder	1/	2/	3/	4/	5/	6/	12
No. T / Missing								
No. T / Filled								
Total D.M.F.T.								
For Extraction								
For Filling								
Total Sound teeth								

**SYMBOL FOR MOUTH EXAMINATION**

- X - Carious tooth indicated for extraction
- D - Carious tooth indicated for filling
- RF - Root fragment
- M - Missing tooth
- F2 - Permanently filled tooth with recurrence of decay

- (✓) - Sound/erupted Permanent tooth
- PFS - Pit and Fissure Sealant
- JC - Jacket Crown
- P - Pontic
- RPD - Removable Partial Denture

- FB - Fixed Bridge
- CD - Complete Denture
- GI - Glass Ionomer
- CO - Composite
- AM - Amalgam

**INTERVENTION/TREATMENT RECORD**

Date	Chief Complaint	Intervention/Treatment Done	Remarks	Attended by (Name/Position)



Republic of the Philippines  
Department of Education  
Region \_\_\_\_\_  
Division of \_\_\_\_\_

**REFERRAL SLIP**

To \_\_\_\_\_ Date \_\_\_\_\_  
(Agency)

Address \_\_\_\_\_

This is to refer to you:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address/School: \_\_\_\_\_ Grade: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Impression: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_  
Name and Signature

\_\_\_\_\_  
Designation

Note: To be detached from upper portion and sent back to the school.

**Return Slip**

Returned to \_\_\_\_\_

Name of Patient \_\_\_\_\_ Date Referred \_\_\_\_\_

Chief Complaint \_\_\_\_\_

Findings \_\_\_\_\_

Action/Recommendations \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name & Signature

\_\_\_\_\_  
Designation



Republic of the Philippines  
DEPARTMENT OF EDUCATION

Region: \_\_\_\_\_

Division of: \_\_\_\_\_

**DENTAL REFERRAL FORM**

Patients Name: \_\_\_\_\_

Age: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Dear Dr.: \_\_\_\_\_

I am referring \_\_\_\_\_ to your office for:

Oral Prophylaxis

Restoration

Extraction

Other Procedures: \_\_\_\_\_


Note: (Example: Resto#16, Exo #46) If OUT is needed

Sincerely:

\_\_\_\_\_  
School Dentist

Kindly return Dental Slip

**DENTAL TREATMENT RETURN SLIP**

Dental Procedure done:

Oral Prophylaxis \_\_\_\_\_

Restoration \_\_\_\_\_

Extraction \_\_\_\_\_

Other Procedures: \_\_\_\_\_

Signature:

**DENTIST'S NAME:**

Lic. No.:

## TEACHER'S HEALTH EXAMINATION RECORD

Name: \_\_\_\_\_ Division: \_\_\_\_\_ Department: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Type of Work: \_\_\_\_\_ Sex: \_\_\_\_\_ Civil Status: \_\_\_\_\_

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