



2020 - 01523

Republic of the Philippines
Department of Education
REGION X
DIVISION OF MALAYBALAY CITY

DM - 2020-02-76
DEPED MALAYBALAY CITY DIVISION
RELEASED
DATE: 12 2020 TIME: 8:40
BY: [Signature]

Division MEMORANDUM

No. **76**, s. 2020

TO: Assistant Schools Division Superintendent
Chief Education Supervisors, SGOD and CID
Public and Private Secondary and Elementary School Heads
All Others Concerned

FROM: **VICTORIA V. GAZO**
Schools Division Superintendent

DATE: February 11, 2020

**SUBJECT: ONLINE REFERRALS OF PERSONS WITH SYMPTOMS OF
RESPIRATORY INFECTION (RPSRI) MONITORING FORM**

1. Pursuant to DepEd Memorandum No. 15, s. 2020 re: First Set of Policy Directives of the DepEd Task Force nCoV, close monitoring of the health status of personnel and learners is directed.
2. School Heads are instructed to accomplish the Online Referrals of Persons with Symptoms of Respiratory Infection (RPSRI) Monitoring Form weekly. The online form can be accessed through <http://deped.in/rpsri>. School Heads of Private Schools are encouraged to do the same.
3. All schools shall utilize existing referral systems as indicated in the School Health and Nutrition Service Manual for personnel and learners who are exhibiting symptoms of respiratory infection. The Medical Referral Form is attached in this memorandum.
4. Should there be queries, contact **Jimdandy S. Lucine**, Project Development Officer II (DRRM), through **09171156864**.

Encls: As Stated

Copy Furnished: Records Unit | DRRM | School Health Section



Address: Sayre Highway, Purok 6, Casisang, Malaybalay City
Telefax: (088) 314 - 0094
Email Address: malaybalay.city@deped.gov.ph

Republic of the Philippines
DEPARTMENT OF EDUCATION
Region _____
Division of _____

School Name/ID

MEDICAL REFERRAL FORM

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.

Name of Institution

Medical Treatment Return Slip

Returned to _____

Name of Patient _____ Date Referred _____

Chief Complaint _____

Findings _____

Action/Recommendations _____

Date

Name & Signature

Designation



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