Republic of the Philippines
Department of Education
REGION III
SCHOOLS DIVISION OFFICE OF BATAAN

APR 26 2021

DIVISION MEMORANDUM
No. 128, s. 2021

FLU VACCINATION FOR SDO PERSONNEL

To: OIC - Assistant Schools Division Superintendent
Division Chiefs, CID and SGOD
Education Program Supervisors
Public Schools District Supervisors
SDO Personnel
All Others Concerned

1. To better serve its clientele with enhanced immune system, this Office announces the **Flu Vaccination for SDO Personnel** on May 10 – 11, 2021 at the SDO Conference Hall at 8am to 12pm.

2. The following schedule will be strictly followed:

May 10, 2021 (AM)	Time	May 11, 2021 (AM)	Time
Office of the SDS and ASDS/CID /PSDS	8:00-9:00	SGOD/Engineering/ Records	8:00-9:00
Personnel	9:00-10:00	LRMDS/Supply/ICT	9:00-10:00
Finance/Budget	10:00-11:00	School Health and Nutrition	10:00-11:00
Auditor/Cash/Planning	11:00-12:00		

3. Minimum health and safety protocols must be observed at all times.

4. Attached is the vaccination plan and medical examination report, fill up and bring at the time of vaccination.

5. Wide dissemination of this Memorandum is desired.

ROLAND M. FRONDA, EdD, CESO VI
Assistant Schools Division Superintendent
Officer – In – Charge
Office of the Schools Division Superintendent

SO12
April 23, 2021

Republic of the Philippines
Department of Education
Region III
Schools Division Office of Bataan

Website: www.depedbataan.com | email: bataan@deped.gov.ph | FB Page: https://www.facebook.com/DepedBataan

Control Number:		MEDICAL EXAMINATION REPORT			
COMPLETE NAME:		CIVIL STATUS	DATE OF BIRTH	SEX ☐ M ☐ F	
DIVISION		POSITION		AGE	
FIRST PART: MEDICAL HISTORY AS STAED BY PATIENT DURING INTERVIEW				CP#:	

ANY HISTORY OF PREVIOUS HOSPITALIZATION OR SURGICAL OPERATION? ☐ YES ☐ NO PLEASE SPECIFY: _____	PRESENT MEDICATION TAKEN WITHIN 30 DAYS: ☐ YES ☐ NO PLEASE SPECIFY: _____
ANY HISTORY OF ACCIDENTS/INJURIES? ☐ YES ☐ NO PLEASE SPECIFY: _____	PREGNANT: ☐ YES ☐ NO PLEASE SPECIFY: _____
ANY HISTORY OF MENTAL OR PSYCHOLOGICAL PROBLEM? ☐ YES ☐ NO PLEASE SPECIFY: _____	ANY PRESENT CONDITION: ☐ YES ☐ NO PLEASE SPECIFY: _____
ANY HISTORY OF ALLERGIES/ASTHMA? ☐ YES ☐ NO PLEASE SPECIFY: _____	OTHERS:
FAMILIAL DISEASE: _____ ☐ YES ☐ NO ☐ MOTHER SIDE _____ ☐ FATHER SIDE _____	

SECOND PART:

1. DO YOU FEEL SICK OR HAVE FEVER TODAY?	YES	NO	VITAL SIGN:
2. HAVE YOU EVER HAD A SERIOUS REACTION TO A FLU VACCINE?	YES	NO	BLOOD PRESSURE: _____ PULSE RATE: _____ VISION: ( ) WITH GLASSES R: _____ ( ) WITHOUT GLASSES L: _____ HEIGHT: _____ WEIGHT: _____ BODY TEMPERATURE: _____
3. DO YOU HAVE AN ALLERGIES TO EGGS, EGG PROTEIN, MSG, GENTAMICIN, GELATIN, ARGININE, NEOMYCIN, POLYMYXIN B, THIMEROSAL, FORMAIDEHYDE, LATEX, OR OTHER VACCINE COMPONENTS?	YES	NO	
4. ARE YOU PREGNANT OR PLANNING ON BECOMING PREGNANT IN THE NEXT MONTH?	YES	NO	
5. DO YOU HAVE CHRONIC HEALTH PROBLEM SUCH AS: ASTHMA, HEART DISEASE, LUNG DISEASE, KIDNEY DISEASE, NEUROLOGIC OR NEUROMUSCULAR DISEASE, LIVER DISEASE, METABOLIC DISEASE (e.g., DIABETES) OR A BLOOD DISORDER?	YES	NO	
6. DO YOU LIVE WITH, OR EXPECT TO HAVE CLOSE CONTACT WITH, SEVERELY IMMUNOCOMPROMISED INDIVIDUALS LIVING IN A PROTECTIVE ENVIRONMENT (e.g., IN ISOLATION)?	YES	NO	
7. HAVE YOU EVER BEEN VACCINATED FLU VACCINE BEFORE?	YES	NO	

I hereby authorized the official medical examiner and examining physician/s to furnish information that the institution may need pertaining to my health status and other pertinent medical findings and do hereby release them from any and all legal responsibilities by so doing. I also further certify that the medical history contained herein is true to the best of my knowledge.

_____
Patient/Employee's Signature

Flu Vaccination Plan