



Republic of the Philippines
Department of Education
REGION VI – Western Visayas
SCHOOLS DIVISION OF SAGAY CITY

SEP 10 2024

DIVISION MEMORANDUM

No. 559, s. 2024

**GUIDELINES ON THE CONDUCT OF MEDICAL EXAMINATIONS OF ATHLETES,
COACHES AND ASST. COACHES FOR SY 2024-2025**

TO: Asst. Schools Division Superintendent
Chiefs of CID and SGOD
All Public Schools District Supervisors
All Public & Private Elementary & Secondary School Heads
All District Sports Coordinators
All Others Concerned

1. In preparation for the upcoming Division Meet and subsequent higher-level athletic events for the school year 2024-2025, and in compliance with DM 534, s. 2024, titled 'Guidelines on the Conduct of Lower Athletic Meets up to Palarong Pambansa for S.Y. 2024-2025', it is mandatory for all athletes to undergo a **Pre-Participation Physical Evaluation (PPE)**. This evaluation is crucial for ensuring that athletes are in optimal health and fully prepared for participation in these athletic events.

2. To ensure that all district delegates are properly accommodated by the School Health and Nutrition Section (SHNS) Medical Officer III, who will be conducting the Pre-Participation Physical Evaluation (PPE), the following guidelines for medical examination must be observed:

- a. **On the day of medical examination**, coaches shall bring the following documents:
 - i. **Parental consent** for medical examination (duly signed by the parent/guardian, NO SIGNED PARENTAL CONSENT NO MEDICAL EXAMINATION) (prescribed by the NSAC);
 - ii. **Pre-participation Physical Evaluation (PPE) History Form** (note: this form MUST be answered and signed by the PARENT/ GUARDIAN before the scheduled medical examination, unanswered and no parent's/ guardian's signature, NO MEDICAL EXAMINATION) (*refer to the Enclosure 1*);
 - iii. **Medical and Dental Form for ATHLETES** (prescribed by the NSAC);
- b. **For athletes with special needs**, aside from PPE and parental consent, coaches shall bring the **supplemental history form** filled out by the parent/ guardian (*refer to Enclosure 2*);
- c. **All athletes** are advised to undergo medical examination at least 14 days before the sports event to give time for any treatments/ interventions requested by the Medical Officer if the athlete is found unfit to play, however if this is not possible, those learners identified unfit to play during medical examination will be endorsed to the Division Sports Coordinator and will not be eligible to play;
- d. **All athletes** scheduled for medical examination shall be **accompanied by their teacher/adviser/coach**;
- e. **Athletes with special needs shall be accompanied by their parent/guardian**;



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- f. To ensure the quality of medical examination, a **maximum of 120 athletes per day** shall be accommodated;
- g. In **preparation for the District Meet**, the **District Supervisor and or the District Sports coordinators** from each district shall submit a letter of request for a medical check-up addressed to **Dr. Dominique C. Diamante, Medical Officer III** of this division. The deadline for the **submission of this request will be on or before September 27, 2024 for the District Meet Level and October 21, 2024 for the Division Meet**, submit letter to Nurse Lisette Grace Cabalang. Strictly no letter requests no medical examination schedule.
- h. The letter shall contain the following information (refer to Enclosure 3 for the template):
- District
 - Name and Contact Number of the District Sports Coordinator
 - Number of athletes joining each sports event (eg. Basketball- 18 athletes)
 - Total number of athletes from the District
 - Tentative Venue of medical examination
 - List of Names with Gender of all District/Division Athletes (to follow on the day of Medical Examination)
- i. The schedule of the **medical examination in preparation for the District Meet will be on October 1-15, 2024 only;**
- j. **For the Division Meet 2024, the Medical and Dental Check-up will be on October 21-25, 2024 only;**
- k. It is understood that SHNS Nurse Lisette Grace Cabalang will be the one to give the requesting party their final medical examination schedule. Scheduling will be on a **FIRST SUBMISSION of Letter Request, FIRST TO BE SERVED BASIS;**
- l. Athletes unable to participate during the medical examination schedule shall be referred to the Sagay City Health Office.
3. Expenses such as transportation, meals, and other incidental expenses relative to the conduct of this activity are chargeable to School MOOE or other local funds, subject to the usual accounting and auditing rules and regulations.
4. It is understood that in the conduct of this activity, there shall be no discrimination on account of age, school, gender, civil status, disability, religion, or other similar factors, or personal circumstances that run counter to the principles of equal opportunity
5. Immediate and widest dissemination of and strict compliance with this Memorandum are desired.


MARSETTE D. SABBALUCA, CESO VI
Schools Division Superintendent 

No. of Pages including this document: 7 pages

Reference: DM 534, s. 2024

Enclosure: 1 Pre-participation Physical Evaluation Form 2 Supplementary history form Enclosure 3 Letter Request Template

To be indicated in the Perpetual Index under the following subjects:

SPORTS

MEDICAL

ATHLETES

lgbcabalang/ **GUIDELINES ON THE CONDUCT OF MEDICAL EXAMINATION FOR ATHLETES SY 2024-2025**



Telephone No: (034) 488-02-15 to 16; 722-36-78; 722-21-95

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 DepEd Tayo Sagay City

ENCLOSURE 1. Pre-participation Physical Evaluation Form (2 Pages)

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) DOMINIQUE C. CHEUNG, MD Date _____

Address Schools Division Office, Brgy. Rizal, Sagay City Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

ENCLOSURE 2. Supplementary History Form for *athletes with special needs* (2 Pages)

**■ PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS:
SUPPLEMENTAL HISTORY FORM**

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

Cleared for all sports without restriction
 Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

Not cleared
 Pending further evaluation
 For any sports
 For certain sports _____
Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) DOMINIQUE C. CHEUNG, MD Date _____
Address Schools Division Office, Brgy. Rizal, Sagay City Phone _____
Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____



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ENCLOSURE 3. Letter Request Template

Date: _____

DR. DOMINIQUE C. DIAMANTE
MEDICAL OFFICER III
SCHOOL HEALTH & NUTRITION SECTION

Dear Doctor:

Respectfully requesting for an appointment for the conduct of Medical Examination of our Athletes for the upcoming District/ Division Meet.

District	
Name of District Sports Coordinator	
Sports Coordinator Contact Number	
Number of athletes joining each sports event:	
<ol style="list-style-type: none"> 1. Aerogymnastics 2. Arnis 3. Athletics 4. Badminton 5. Baseball 6. Basketball 7. Billiard 8. Chess 9. Dance Sports 10. Football 11. Futsal 12. Sepak Takraw 13. Swimming 14. Table Tennis 15. Taekwondo 16. Tennis 17. Volleyball 18. Paragames 	
TOTAL number of athletes	
Tentative Venue of medical examination	
Masterlist of athletes with gender (to follow on the day of Medical Exam Schedule)	

Respectfully,

Signature over Complete Name of District Sports Coordinator

Noted by:

District PSDS Signature over Complete Name



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