



Republic of the Philippines
Department of Education
 Negros Island Region
SCHOOLS DIVISION OF SAGAY CITY

FEB 06 2026

DIVISION MEMORANDUM
 No. 084, s. 2026

**ORAL HEALTH AWARENESS AND MONTH-LONG CELEBRATION OF THE
 22nd NATIONAL DENTAL HEALTH MONTH CELEBRATION**

To: Assistant Schools Division Superintendent
 Chief of Education Supervisors – CID & SGOD
 Public Schools District Supervisors
 Public Elementary and Secondary School Health
 All Others Concerned

1. In accordance with Presidential Proclamation No. 559, which designates February as National Dental Health Month, the School Division Office of Sagay City, through the Health and Nutrition Unit Division, will conduct a month-long celebration of **Oral Health Awareness and the 22nd National Dental Health Month** to promote oral health. The celebration carries the theme, “Dentista’y Kaagapay sa Ngiting Walang Humpay.” A launching activity will be held on February 20, 2026, at 9:00 in the morning, at Romeo V. Agustin Elementary School.
2. This activity aims to:
 - a. promotes awareness about the importance of good oral hygiene and to encourage healthy habits through oral health education among students.
 - b. guide and educate learners about the significance of brushing, flossing, and encourage regular dental visits in maintaining overall health.
 - c. promote the prevention of dental problems, such as cavities and gum disease, and emphasizes the role of nutrition in oral health.
3. All schools are encouraged to organize a school-based simultaneous toothbrushing and handwashing activity for all Bright Smile Bright Future (BSBF) kit beneficiaries on February 20, 2026 and to submit MOVs and narrative printed report to the Division Dentists. (Please refer to ANNEX A for the list of all BSBF kit Beneficiaries).
4. Herewith is the Parent’s Consent Form for the Fluoride Application (See ANNEX B), and Parent’s Consent Form for the Tooth Extraction Procedure. (See ANNEX C)
5. Additionally, the School Health and Nutrition Unit will conduct a Health and Dental Assessment to all learners to schools, following the schedule stated in the Division Memorandum No. 054, s. 2026 (Mandatory Health Assessment to all Learners for SY 2025-2026).
6. Expenses of schools that will conduct these activities shall be taken from local school fund/MOOE subject to the usual accounting and auditing procedures.
7. The Data Privacy Act and related policies of the DOH and DepEd shall be followed in the handling and sharing of data.
8. It is understood that in the conduct of this activity there shall be no discrimination in the provision of such partnership on account of age, school, gender, civil status, disability, religion or other similar factors, personal circumstances that run counter to the principles of equal opportunity.
9. Immediate and wide dissemination and compliance of this Memorandum is desired.

DANNIE CLARK M. UGUIL, CESE

Assistant Schools Division Superintendent
 Officer-in-Charge

Office of the Schools Division Superintendent

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Enclosure : As stated
 Reference : As stated
 Allotment : N/A
 No. of Pages : 2

To be indicate in the **Perpetual Index** under the following subjects:

22nd NATIONAL DENTAL HEALTH MONTH HEALTH ASSESMENT SCHOOL HEALTH UNIT WASH IN SCHOOL (WinS)

FN: mcp/SGOD



Sitio Chloe, Brgy. Rizal, Sagay City, Negros Occidental
 Telephone Nos. 488-02-15; 722-0597



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ANNEX A- of Division Memorandum No. 08s. 2026

		SCHOOL NAME	KINDER		GRADE 1		
			TOOTH PASTE	TOOTH BRUSHES	TOOTH PASTE	TOOTH BRUSHES	
			QTY indicated in the Box	QTY indicated in the Box	QTY indicated in the Box	QTY indicated in the Box	
DISTRICT IA	1	117696	Jose B. Puey Sr. Elementary School	20	303	21	312
	2	117690	Alfredo E. Marañon Sr. Elem. School	5	70	6	83
	3	117691	Alfredo E. Marañon Sr. Elem. School (SOF)	2	24	1	13
	4	117694	General Luna Elementary School	5	69	4	54
	5	305536	Trinidad Lopez De Gonzaga NHS				
	6	343922	Sagay City Senior High School				
	7	311802	Sagay City Farm School				
DISTRICT IB	8	117700	Old Sagay Elem. School	17	257	17	248
	9	117695	BV Rodriguez Elem School	8	113	8	113
	10	117706	P.R. Katalbas I Elementary School	1	18	1	19
	11	117702	P.R. Katalbas II Elementary School	2	34	2	36
	12	117705	Suyac Elementary School	1	16	1	14
	13	117710	B. Mahilum IS	1	10	1	10
	14	311801	Old Sagay National High School				
DISTRICT IC	15	117704	Raymundo Tupas ES/	7	98	7	105
	16		Raymundo Tupas SESCO Extn.	1	13	1	19
	17	117693	Bulanon Elem.School	4	56	3	49
	18	117701	Onofre dela Paz Elem. School	1	10	2	25
	19	117707	Talusan Elem. School	10	128	9	130
	20	117703	Plaridel Elem. School	3	45	3	50
	21	302768	Bulanon Farm School & SHS				
DISTRICT ID	22		Bulanon NHS-Onofre Extension				
	23	117709	Vito Elem. School	6	85	6	90
	24	117692	Elia T. Canoy-Esperancilla ES	5	67	5	79
	25	117697	Matabas Elem. School	1	16	1	12
	26	117699	Molocaboc II Elem. School	1	19	2	22
	27	117708	Tuong Elementary School	2	26	2	34
	28	302771	Vito National High School & SHS	17	257	17	248
DISTRICT IE	29	500040	Molocaboc Integrated School - Elem & Junior	4	54	4	52
	30	117721	Maria Lopez Elementary School	15	219	13	192
	31	117722	Ricardo Gamboa Elementary School	6	89	5	74
	32	117712	Cesar Gamboa Elementary School	2	28	2	26
	33	117711	Raynor Mesa Elementary School	1	16	1	13
	34	117723	Sir Arthur Cooper Elementary School	2	36	2	34
	35	305800	Sagay City Eco-zone NHS				
DISTRICT IIB	36	302767	Sagay NHS-Main				
	37	500037	Eusebio Lopez Memorial IS - Elem.,JHS, SHS	8	122	9	130
	38	117719	Josebio L. Gonzaga Memorial School	4	53	4	63
	39	117720	Josebio Gonzaga ES - Extension	2	36	2	29
	40	117716	Gil Lopez Elementary School	7	102	9	131
	41	117715	Filomeno Pascual Elem. School	1	20	1	12
	42	117714	Fabrica Elementary School				
DISTRICT IIIA	43	117717	Hautea Integrated School	3	39	3	44
	44	500038	Himogaan Baybay IS - Elem, JHS, SHS	5	76	6	87
	45	117733	Lopez Jaena Elem. School	4	56	5	68
	46	311803	Jesus Lizares National HS				
	47	117726	Briones-Salcedo Elem. School	2	31	2	33
	48	117728	Campo Himogaan Elem. School	3	51	2	28
	49	184001	Uychiat Elem. School	2	24	2	22
DISTRICT IIIB	50	502849	Valeria G. Añalucas Integrated Sch	1	15	2	23
	51	117724	Bato Central Elem. School	5	79	9	97
	52	117725	Baviera Elementary School	2	25	2	36
	53	117738	Pacol Elementary School	1	11	1	16
	54	302762	Bato National High School - JHS & SHS				
	55	305537	Patricio Baviera National High School				
	56	501794	Sherman Hill Integrated School - Elem. & Sec.	2	34	2	33
DISTRICT IIIC	57	117737	Maquiling Elem. School	5	79	4	58
	58		Crossing Bago Elementary School	3	41	2	35
	59	117727	Melchor D. Salcedo Elem. School	5	71	5	78
	60	117734	Macamilco Elem. School	1	12	1	11
	61	302763	Cpo. Bago National HS & SHS				
	62	117736	Manara Integrated School	1	14	1	18
	63	500036	Colonia Divina IS - Elem, JHS and SHS	2	36	2	35
DISTRICT IIID	64	117732	Laon Elementary School	1	17	1	16
	65	117731	Hamticon Elem. School	1	14	1	18
	66	117729	Campo Santiago Elem. School	1	20	1	21
	67	117739	Rufino T. Halipa Sr. Elementary School	1	20	1	19
	68	302770	Sewahon National High School				
	69	500039	Serafin V. Aguilar IS - Elem and HS	2	23	2	28
			TOTAL	225	3297	229	3,345



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ANNEX B- of Division Memorandum No. 084 s. 2026

DENTAL TREATMENT CONSENT FORM

Patient Information:

- **Patient Name:** _____ **Date of Birth:** _____
- **Grade/Class:** _____ **School Name:** _____

Description of Treatment:

As part of our commitment to promoting dental health, the school is offering dental consultation and/or fluoride application to help prevent tooth decay and support oral hygiene.

- **Type of procedure (Pls Encircle):** Consultation; Fluoride Application
- **Description of Procedure:** A topical fluoride gel will be applied to your child's teeth to help prevent cavities.
- **Date of Procedure:** _____ **Location:** _____

Potential Risks and Benefits:

- **Benefits:** Prevents cavities, strengthens tooth enamel, promotes overall oral health.
- **Risks:** Mild irritation to gums may occur, though rare.

Parent/Guardian Consent:

By signing below, I, the undersigned, give my permission for my child to receive the specified treatment outlined above. I understand that the treatment is safe and commonly used, and that the staff performing the procedure are trained professionals. I also acknowledge that I have had the opportunity to ask questions and that I understand the procedure and its potential risks and benefits.

I approve and consent to the use of recordings, films, or other pictures of myself (i.e., photos, videos) for identification, diagnosis, and treatment in connection with the care I receive.

The Department of education shall engage in the collection of health/medical information for tracking, provision of necessary health/ medical interventions, and educational purposes. This information shall be processed in accordance with the provisions of the Data Privacy Act and Date Privacy Policies of the Department.

This information shall be stores and held confidentially in accordance with the provisions of the Basic Education Act and may only be shared with other government agencies or other parties subject to Data sharing agreement and data privacy requirements for legitimate purposes only. I hereby authorize the Department of Education to use, collect, and process the information for the purposes of the above-stated.

- **Parent/Guardian Name:** _____
- **Parent/Guardian Signature:** _____ **Date:** _____

Alternative Treatment:

If you do not wish for your child to receive this treatment, please indicate your preference below:

I do not give consent for my child to receive the treatment.

Emergency Contact Information:

In case of any emergencies or questions during the treatment, please contact:

- **Emergency Contact Name:** _____
- **Phone Number:** _____



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ANNEX C- of Division Memorandum No. 081s. 2026

Name: _____ Age: _____ Sex: _____
 Grade Level: _____ Position (for Personnel only): _____
 School: _____
 Address: _____

Blood Pressure: ____ mmHg Temperature: ____ Respiratory Rate: ____
 Heart Rate: _____ Oxygen Saturation: _____

	YES	NO	REMARKS		YES	NO	REMARKS
Allergy (Pls. Specify)				Kidney Disease			
Asthma				Thyroid Problems			
Anemia				Liver Disease			
Hypertension				Hepatitis (Pls. Specify)			
Cardiovascular Heart Disease				Circumcised (Male)			
Blood Disorder				ON Menstrual Period (female)			
Epilepsy				Other Conditions			
Diabetes Mellitus				ON Any Medication			

1. I understand that alternative to tooth removal (root canal therapy, crowns & periodontal surgery, etc.)
2. I completely understand these alternatives, including their risk & benefits prior to authorizing the dentist to remove teeth & any other structures necessary for reasons above. I understand that removing teeth does not always remove all the infections, if present, & it may be necessary to have further treatment.
3. I Have been informed of the need for dental Extraction (Removal of Unsaveable tooth/teeth). The reasons for this extraction have been explained to me clearly.
4. I have been informed of the risk related to surgery that might include, but are not limited to, post-surgical infection, bleeding, swelling, pain, (dry socket), face discoloration, fractured jaw or associated muscle spasm, fracture of the tooth/teeth during surgery, retention of part of the tooth, dislodgement of the part of the tooth to the sinus, shrinkage of gum upon healing. Risks related to the anesthesia might include, but are not limited to allergic reactions, accidental swallowing/aspiration of foreign matter, facial swelling/bruising, or discoloration at the site of injection, loss of feeling on the teeth, lips, tongue & surrounding tissue that can last for an indefinite period of time. I understand that I may need further treatment under a specialist if complications arise during or following treatment.
5. To my knowledge, I have given an accurate report of my physical and mental health history and current conditions.
6. I have also given permission to photography and or/video recording of any procedure.
7. That I have fully read and understand this consent form. I hereby consent DepEd Sagay Dental Unit to do such surgical procedure and in cases unforeseen circumstances they will not be held liable.

Name & Signature of Patient (Parent or Legal Guardian):

_____ Date: _____

Diagnosis: _____ Treatment: _____

