June 29, 2026

DIVISION MEMORANDUM
No. 198 s. 2026

IMPLEMENTATION OF THE MEDICAL RESPONDERS REQUEST FORM FOR OFFICIAL DIVISION AND SCHOOL ACTIVITIES

To: Assistant Schools Division Superintendent
Chief Education Supervisor, SGOD & CID
All Elementary School Heads
All Secondary School Heads
All Others Concerned

1. This Office, through the School Health and Nutrition Unit (SHNU), shall adopt the Implementation of the Medical Responders Request Form for Official Division and School Activities. (Enclosure 1. Medical Responder Request Form)

2. All requesting offices shall accomplish the Medical Responders Request Form completely and accurately. The accomplished request form shall be submitted to the School Health and Nutrition Section (SHNS)/Medical Unit at least **three (3) working days** prior to the scheduled activity. Any cancellation, postponement, or modification of the activity shall immediately be communicated to the School Health and Nutrition Section.

3. This activity aims to ensure the availability of timely and appropriate medical assistance during official activities, all requesting offices, units, schools, and program implementers are hereby directed to utilize the **Medical Responders Request Form** for any activity requiring the services of designated medical responders.

4. This activity shall adhere to the Equal Opportunity Principle (EOP) in observing all policies and protocols of the said activity. Hence, all actions shall be based solely on guidelines set with no discrimination on the account of age, gender identity, sexual orientation, civil status, disability, religion, ethnicity or political affiliation.

4. For dissemination, guidance and compliance.

RANDOLPH B. TORTOLA
Schools Division Superintendent

To be indicated in the Perpetual Index
under the following subjects:
SHNU
MEDICAL RESPONDER REQUEST FORM
SGOD/SHNU/*vplt*

Enclosure 1.

REQUEST FORM FOR MEDICAL RESPONDER

Date of Request: _____

Requesting Unit/Office/School: _____

Name of Program/Activity: _____

Venue: _____

Date & Time of Program/Activity: _____

Number of Expected Participants: _____

Type of Medical Support Needed (check all that apply):

☐ On-site Medical Responder

☐ First Aid Support

☐ Others (please specify): _____

Brief Description of Activity: _____

_____

Name of the Coordinator: _____

Position/Designation: _____

Approved by:

_____

(Please include the name(s) of the medical responder in the memo for the activity to be conducted.)

(Kindly prepare two (2) copies: one for the Medical Section and one for the Program Proponent.)