



Republic of the Philippines  
Department of Education  
REGION IV-A CALABARZON  
CITY SCHOOLS DIVISION OF BIÑAN CITY

DEPARTMENT OF EDUCATION  
Schools Division of Biñan City  
RECORDS SECTION  
RECEIVED APR 28 2025  
By: *J. M. de Leon*

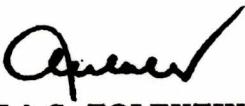
25 Apr 2025

**DIVISION MEMORANDUM**  
No. 146, s. 2025

**SUBMISSION OF OKD PROGRAM YEAR-END REPORTS**

To: Assistant Schools Division Superintendent  
Chief, School Governance and Operations Division  
Chief, Curriculum Implementation Division  
All Schoolheads

1. Pursuant to DO 28, s. 2018 "Oplan Kalusugan sa DepEd (OKD)", all schools are directed to submit year-end reports of the OKD programs as enumerated below on or before May 2, 2025.
2. For School Mental Health and Adolescent Reproductive Health programs, furnish required data using the link below:
  - a. Mental Health Data: [bit.ly/3SbOEJD](https://bit.ly/3SbOEJD)
  - b. Teenage Pregnancy: [bit.ly/3EJQWg0](https://bit.ly/3EJQWg0)
  - c. Psychosocial Referral: [bit.ly/3Eq0nkR](https://bit.ly/3Eq0nkR)
  - d. HEEADSSS Assessment: [bit.ly/3S7mwr6](https://bit.ly/3S7mwr6)
3. For Health Services and Gulayan sa Paaralan, you may download the forms through this link: <https://bit.ly/3GC6SS4> and submit accomplished reports to SDO Records Section. See attached templates as reference.
  - a. OKD Accomplishment Report
  - b. SDHCP Form 3 & SHD Form 5A
  - c. GPP Terminal Report & Accomplishment Report (Annex 3)
  - d. ISNM Accomplishment Report (Lighthouse Schools only)
4. For queries, please contact Ms. Henrietta M. Nacario, RN – School Health Section through (049) 511-4191 loc. 129 or email at [henrietta.nacario@deped.gov.ph](mailto:henrietta.nacario@deped.gov.ph)
5. Immediate and widest dissemination of this Memorandum is desired.

  
**MANUELA S. TOLENTINO, CESO V**  
Schools Division Superintendent

Encl: As stated

Reference:

SGOD/SH / HMN / HMN / DM – Submission of OKD Program Year-End Reports  
/ 04/25/2025



Address: 102 P. Burgos St., Brgy. Sto. Domingo, Biñan City, Laguna  
Contact Nos.: (049) 547-0105 | (049) 530-1592 | (049) 254-0565  
Email Address: [deped.binancy@deped.gov.ph](mailto:deped.binancy@deped.gov.ph)  
Website: [www.depedbinancy.ph](http://www.depedbinancy.ph)



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Republic of the Philippines  
**Department of Education**  
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**GULAYAN SA PAARALAN (GPP) TERMINAL REPORT**

School Year \_\_\_\_\_

(NAME OF SCHOOL) \_\_\_\_\_

**I. SCHOOL GARDEN**

Name of Crops	Type of Garden (Urban/ Rural)	Total No. Harvested (In kilos)	Total No. Sold (In kilos)	Total No. Used for Feeding (In kilos)	Monetary Equivalent
<b>TOTAL:</b>					

**II. SCHOOL NURSERY**

Type of Seedings	Number of Seedings Propagated	Number of Seedings utilized	Number of Seedings Distributed to other schools

**III. SCHOOL CROP MUSEUM (write NA if not applicable)**

Type of Seedings	Number of Seedings Propagated	Number of Seedings Distributed	Name of School recipients
<b>TOTAL:</b>			

**IV. FUND UTILIZATION**

Fund source (CO, MOOE, Sold Crops, Cash Donations)	Fund Amount	Name of Items Procured	No. of Items Procured	Amount Utilized
<b>TOTAL:</b>				

#### V. STAKEHOLDERS/PARTNERS/BENEFACATORS

Name of Institution/Company/ Individual/Others	Type of Donations (cash/goods/ others)	Number/Name of Items Donated (cash/goods)	Amount (cash or monetary value)
<b>TOTAL:</b>			

#### V. Personnel/Individual Involved

#### VI. Photo Documentation

Prepared by:

#### SIGNATURE OVER PRINTED NAME

School GPP Coordinator

Reviewed by:

#### SIGNATURE OVER PRINTED NAME

School Nutrition Coordinator

Approved by:

#### SIGNATURE OVER PRINTED NAME

Schoolhead

## Annex 3

**Gulayan sa Paaralan Program (GPP) Accomplishment Report  
for the Utilization on the 2024 Downloaded Funds**

Division/School:	BINAN CITY/	Period Covered:
Office Address:		
Office Telephone Number:		

**A. ACCOMPLISHMENTS**

<b>1. Number of Schools received the downloaded funds</b>	N/A
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**2. School Garden**

Name of School	Type of Garden	Total Number of Vegetable Harvested (in Kilos)	Total Number of Vegetable Sold (in Kilos)	Total Number of Vegetable Used in Feeding Program
<b>Total</b>				

**3. School Nursery**

Name of School	Type of Seedlings	Number of Seedlings Propagated	Number of Seedlings Distributed
<b>Total</b>			

**4. Activities conducted for GPP**

Activity Conducted Checklist	/ or X
Conducted Capacity-Building/ Training on GPP	
Conducted Advocacy Campaign on GPP	
Conducted Progress Monitoring on GPP	
Conducted the Program Implementation Review on GPP	
Vermiculture	
Urban Gardening	
Hydroponics	
Vertical Gardening	

**5. Fund Utilization**

Name of School	Item Procured	Amount


#### 6. Impact to the Community

Number of Home or Community Gardens	Partner assisted in establishing Home or Community Gardens
Number of Home Gardens established	
Number of Community Gardens established	

#### 7. Donation/Resources Generated

(Add Additional Sheets, if needed)

Partner & Type of Donations/Services Provided	Quantity (if applicable)	Estimated Cost (if applicable)

#### F. PHOTOS (Before, During and After)

Prepared by:

Noted by:

GPP School Coordinator

Date: \_\_\_\_\_

School Head

**Integrated School Nutrition Model (ISNM) Accomplishment Report  
for the Utilization of the 2024 Downloaded Funds**

<b>Division/School</b>		
<b>Name of Lighthouse School</b>		
<b>Amount Downloaded</b>	Advocacy activities conducted on the integration of bio-intensive gardens, school feeding, and nutrition education	
Activity	Date/Time/Venue	

**Did you reproduce or reprint any nutrition education materials? (/)**

Yes \_\_\_\_ No \_\_\_\_

If Yes, what kind of nutrition education materials?  
(e.g. pamphlet, booklet, posters etc.)

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If No, state Why

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**Did you procure garden tools for the improvement/maintenance of vegetable gardens? (/)**

Yes \_\_\_\_ No \_\_\_\_

If yes, state garden tools procured:

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If No, state Why

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**Have you planted indigenous vegetables? Yes \_\_\_\_ No \_\_\_\_**

If Yes, what are those indigenous vegetables, please state:

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If No, state Why

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<b>Problems/issues encountered</b>	<b>Recommendations Made</b>
1.	
2.	
3.	

**Best practices**

1. \_\_\_\_\_
2. \_\_\_\_\_

Prepared by:	Noted by:
School GPP Coordinator	School Head
Date: _____	

(Please attach pictures and provide a caption and date)

**SDHCP Form 3: Nursing Services Accomplishment Report**

Division City:

School:

School Year:

Grade Level	Health talks	Services Rendered	Referral	Sub-total
Kindergarten				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
T/NT				
<b>Grand total</b>				

<b>Number of Schools Visited:</b>	<b>NA</b>
SDHCP Clinic Hubs	
Non SDHCP Clinic Hubs	

<b>Partnership / Linkages Established</b>

<b>Online Seminars/Trainings Attended with Inclusive Dates</b>	
Date	Topic/Course Title

<b>Other Relevant Accomplishment</b>

Submitted By:

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Health/Nutrition Coordinator

Approved:

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School Head

Republic of the Philippines  
**DEPARTMENT OF EDUCATION**  
Region 4A-CALABARZON  
Division of City Division of Biñan City

**MONTHLY / ANNUAL HEALTH SERVICES ACCOMPLISHMENT REPORT**

SY: \_\_\_\_\_

Name of School: \_\_\_\_\_

School ID No.: \_\_\_\_\_

Total No. of Elem. Schools Visited

\_\_\_\_\_

Total No. of Sec. Schools Visited

\_\_\_\_\_

**I. General Information**

A. School Enrolment

Number	Number
--------	--------

a. Male \_\_\_\_\_

b. Female \_\_\_\_\_

B. No. of School Personnel

1. Teaching

a. Male _____	b. Female _____
---------------	-----------------

2. Non-Teaching

a. Male _____	b. Female _____
---------------	-----------------

**II. Health Services**

A. Health Appraisal

1. No. of Assessed:

a. Learners _____	b. Teachers _____
c. NTP _____	

2. No. with Health Problems

a. Learners _____	b. Teachers _____
c. NTP _____	

3. No. of Vision Screening (Learners)

\_\_\_\_\_

B. Treatment Done

a. Learners _____	b. Teachers _____
c. NTP _____	

C. No. of Pupils Dewormed

a. 1st Round _____	b. 2nd Round _____
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D. No. of Pupils Given Iron Supplement

\_\_\_\_\_

E. No. of Pupils Immunized (Specify)

MR - , TD -	MMR -	COVID-19 -
Flu Vaccine -	Pneumovac -	

F. No. of consultation attended

a. Learners _____	b. Teachers _____
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G. Referral (No. Referred to)

a. Physician _____	b. Dentist _____
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d. Other facilities _____	e. RHU/ District/ Provincial Hospital _____
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		Number
III. Health Education		
A. No. of Classes given health lectures:		
B. No. of orientation training conducted to:		
	a. Learners	
	b. Teachers	
C. No. of conferences/meeting with:		
	a. Teachers/ Administrators	
	b. Health officials	
	c. Learners	
	d. Parents	
	e. LGU/Barangay	
	f. NGO's/Stakeholders	
D. Involvement as Resource Person/ Consultant/ Adviser/ Judge		
	a. Health Activities/ programs/ contests	
	b. Class Discussion	
	c. Health Clubs/ Organization	
IV. School Community Activities for Health and Nutrition		
A. PTA/ Homeroom Organization Meetings		
B. Parent Education Seminar/ Workshop/Training		
C. Home Visits Conducted		
D. Hospital Visits made		
V. Common Signs & Symptoms		
A. Nutritional Status		
	a. Normal Weight	
	b. Wasted / Underweight	
	c. Underweight / Severely Wasted	
	d. Overweight	
	e. Obese	
	f. Normal Height	
	g. Stunted	
	h. Severly stunted	
	i. Tall	
B. Vision / Auditory		
Vision		Auditory
a. Passed <u>7380</u> b. Failed <u>25</u>		a. Passed <u>7380</u> b. Failed <u>0</u>
C. Skin and Scalp		
	a. Presence of Lice (Pediculosis)	
	b. Redness of Skin	
	c. White Spots	
	d. Flaky Skin	
	e. Impetigo/Boil	
	f. Hematoma	
	g. Bruises/Injuries	
	h. Itchiness	
	i. Skin lesions	
	j. Acne / Pimple	
	h. Capillary refill greater than 3 seconds	
	i. Others, specify	

## SHD Form 5A

		Number
<b>D. Eye and Ears</b>		
	a. Inflamed fluid	
	b. Eye Redness	
	c. Ocular Misalignment	
	d. Pale Conjuctiva	
	e. Matted Eyelashes	
	f. Eye Discharge	
	g. Ear Discharge	
	h. Impacted Cerumen	
	i. Mucus Discharge	
	j. Nosebleeding (Epistaxis)	
	k. Other, specify	
<b>E. Mouth / Neck / Throat</b>		
	a. Presence of Lesions	
	b. Inflamed Pharynx	
	c. Enlarged tonsilis	
	d. Enlarged lymphnodes	
<b>F. Health and Lungs</b>		
	a. Rales	
	b. Wheeze	
	c. Murmur	
	d. Irregular hear rate	
	e. Colds	
	f. Cough	
	g. Others, specify	
<b>G. Deformities</b>		
	a. Acquired (Specify)	
	b. Congenital (Specify)	
<b>H. Abdomen</b>		
	a. Distended	
	b. Abdominal Pain	
	c. Tenderness	
	d. Dysmenorrhea	
	e. Others, specify	
<b>I. Dental Service</b>		
	1. Gingivitis	
	2. Periodontal Disease	
	3. Malocclusion	
	4. Supernumerary Teeth	
	5. Retained deciduous Teeth	
	6. Decubital Ulcer	
	7. Calculus	
	8. Cleft Lip/ Palate	
	9. Fluorosis	
	10. Others / Specify	
	11. Total # of DMFT	
	12. Total # of dmft	

**SHD Form 5A**

	<b>Number</b>
<b>I. Other Signs &amp; Symptoms Noted:</b>	
1.	tumor on the neck
2.	asymmetrical shoulder
3.	Asthma
4.	Swelling of the parotid area
<b>VI. Remarks:</b>	
_____ _____ _____	

Prepared by:

Health Services Program Coordinator

Noted by:

School Head

\_\_\_\_\_  
Date



**OPLAN KALUSUGAN SA DEPED  
ACCOMPLISHMENT REPORT**  
*(To be accomplished by the School Head)*

DIVISION:	REGION:												
SCHOOL:	SCHOOL ID:												
SCHOOL ADDRESS:													
<p>(Please check appropriate box)</p> <table> <tr> <td><b>Level:</b></td> <td><b>Type of School:</b></td> </tr> <tr> <td><input type="checkbox"/> Elementary</td> <td><input type="checkbox"/> Central School</td> </tr> <tr> <td><input type="checkbox"/> Junior High School</td> <td><input type="checkbox"/> Non-Central School (complete)</td> </tr> <tr> <td><input type="checkbox"/> Senior High School</td> <td><input type="checkbox"/> Multigrade</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Primary School / Incomplete</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Integrated School</td> </tr> </table>		<b>Level:</b>	<b>Type of School:</b>	<input type="checkbox"/> Elementary	<input type="checkbox"/> Central School	<input type="checkbox"/> Junior High School	<input type="checkbox"/> Non-Central School (complete)	<input type="checkbox"/> Senior High School	<input type="checkbox"/> Multigrade		<input type="checkbox"/> Primary School / Incomplete		<input type="checkbox"/> Integrated School
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<input type="checkbox"/> Senior High School	<input type="checkbox"/> Multigrade												
	<input type="checkbox"/> Primary School / Incomplete												
	<input type="checkbox"/> Integrated School												
SCHOOL HEAD:													
CONTACT NUMBER:													

**B. ACCOMPLISHMENTS**  
 Use School Health Division Form 2 as basis for accomplishing this table.

1. Common Signs and Symptoms (as reported by Nurses) –

2. Common Diseases (as diagnosed by Medical Doctors) –

3. Common Dental Problems (as diagnosed by Dentists) –

4. Nutritional Status		Number of Learners	
<b>Body Mass Index-for-Age/ Weight-for-Age</b>	Number of Learners	<b>Height-for-Age</b>	Number of Learners
Severely Wasted/ Severely Underweight		Severely Stunted	
Wasted/ Underweight		Stunted	
Normal		Normal	
Overweight		Tall	
Obese			
<b>TOTAL:</b>			

**E. SIGNIFICANT EVENTS OF SBFP, NDEP, ARH, WINS, AND OTHERHEALTH AND NUTRITION PROGRAMS / EXPERIENCES /GOOD PRACTICES**

(Use separate sheets, if needed)

What happened?	Who were involved?	When?	Outcome: What is/are its important contribution to the Ok sa DepEd Program of the school?

**F. LESSONS LEARNED**

**G. SUGGESTIONS TO STRENGTHEN OK sa DepEd Program (include support needed from Central, Region, and Division Office that can increase the impact of OK sa DepEd Program in your school.)**

### C. SUMMARY OF VOLUNTEER SERVICES

Use OK sa DepEd Form C as basis for accomplishing this table.

**DONATIONS / RESOURCES GENERATED** (Add additional sheets, if needed.)

**H. PROPOSED PLAN OF ACTION FOR NEXT OK sa DepEd health services**

**I. PHOTOS (before, during and after)**

Prepared by:	Date:
<i>Name and Designation</i>	

Submit completed form to the SDO by 1<sup>st</sup> week of March.