



Republic of the Philippines
Department of Education

REGION I

SCHOOLS DIVISION OFFICE OF ALAMINOS CITY

DIVISION MEMORANDUM
DM-2021-108


TO : Heads of Public and Private Schools
All Division Personnel
All Others Concerned

FROM : Schools Division Superintendent

SUBJECT : **Profiling of Teaching and Non-Teaching Personnel for COVID-19 Vaccination**

DATE : April 19, 2021

1. Vaccination is a key component on the roadmap to the new normal. With the adjustment of the vaccine prioritization (from B1 to A4) for basic education front liners, we can speed up the rollout of vaccines among our teachers and non-teaching staff.
2. In an effort to strengthen health awareness on the importance of vaccination, DepEd offices and schools are required to do the profiling of teaching and non-teaching personnel in our division in preparation for their scheduled vaccination with the template provided and to be submitted to the City Health Office.
3. School Heads shall accomplish a soft copy to the Division Office thru SGOD-School Health and Nutrition Unit on or before April 30, 2021 and email to abraham.asto@deped.gov.ph for consolidation. Forms can be downloaded using the link: <https://drive.google.com/drive/folders/1jSQNct0xR2nr3qrJZcmU-alw6dbLKhte?usp=sharing>
4. Attached template form will be the reference in accomplishing the Soft copy. Please keep the hard copy for documentation purposes.
5. For technical assistance in accomplishing the forms, please coordinate with the SGOD-School Health and Nutrition Unit for queries, concerns and further information.
6. For your guidance and compliance.


LORNA G. BUGAYONG PhD, CESO V
Schools Division Superintendent

With hundred reasons to serve!



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MASTERLIST/PROFILING FORM

CATEGORY: (Check only one)

- | | | |
|---|--|---|
| <input type="checkbox"/> Health Care Worker | <input type="checkbox"/> Indigent | <input type="checkbox"/> Essential Worker |
| <input type="checkbox"/> Senior Citizen | <input type="checkbox"/> Uniformed Personnel | <input type="checkbox"/> Other |

CATEGORY ID (Check only one)

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> PRC Number | <input type="checkbox"/> Facility ID Number |
| <input type="checkbox"/> OSCA Number | <input type="checkbox"/> Other ID |

Category ID Number _____ PHILHEALTH ID #: _____ PWD ID # _____
Last Name _____ First Name _____ Middle Name _____ Suffix _____
Contact Number: _____ Sex _____ Birthday _____ Civil Status: _____

Address: _____
Current Residence: Unit/ Building/House#/Street Name: _____ Barangay _____
Municipality: _____ Province: _____ Region _____

EMPLOYMENT STATUS:

- | | | |
|--|---|---------------------------------|
| <input type="checkbox"/> Government Employed | <input type="checkbox"/> Self Employed | <input type="checkbox"/> Others |
| <input type="checkbox"/> Private Employed | <input type="checkbox"/> Private Practitioner | |

DIRECT INTERACTION WITH COVID PATIENT

- Yes No

Profession: _____
Name of Employer: _____ Contact Number of Employer _____
Address of Employer _____

PREGNANCY STATUS:

- Not Pregnant Pregnant

ALLERGIES:

- | | | |
|---|--|---|
| <input type="checkbox"/> Drug Allergy | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Pollen Allergy |
| <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Mold Allergy | |
| <input type="checkbox"/> Insect Allergy | <input type="checkbox"/> Pet Allergy | |

COMORBIDITY:

- YES NO

If YES select the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bronchial Asthma | <input type="checkbox"/> Other, specify _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Immunodeficiency | |

DIAGNOSED WITH COVID 19:

- Yes; Date of first positive Result/Specimen Collection (mm/dd/yyyy) _____
 No

Classification of COVID 19:

- | | | |
|---------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Asymptomatic | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Severe | |

WILLINGNESS TO BE IMMUNIZED: Give me the Reason _____
 YES NO

Do you trust the vaccine? Give me the Reason _____

- YES NO UNKNOWN

SIGNATURE OVER PRINTED NAME: _____

DATE SIGNED: _____