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Republic of the Philippines
Department of Education
REGION III
SCHOOLS DIVISION OF BULACAN

November 13, 2026

DIVISION MEMORANDUM
No. 521, s.2026

IMPLEMENTATION OF PHILHEALTH YAKAP ON-SITE ORIENTATION, REGISTRATION HEALTH CARAVAN AND EYE CARE PROGRAM FOR LEARNERS IN SELECTED MUNICIPALITIES OF BULACAN

To: Assistant Schools Division Superintendents
Division and District Supervisors
Selected District School Heads (Elementary and Secondary)
All others Concerned

1. As per RA 11223 or the Universal Health Care Act and it's Implementing Rules and Regulations, the Schools Division Office of Bulacan in cooperation with Philhealth YAKAP Program through TeleCure Medical and Diagnostic Center will establish partnership for the implementation of Philhealth YAKAP Program.

2. The Proposed Initiative aims to support the health and well-being of learners by bringing accessible, preventive and primary healthcare services directly to participating schools and communities

3. The program includes the following components:

    a. Onsite YAKAP benefits orientation
    b. Onsite Philhealth YAKAP Registration and Enrollment Assistance
    c. School-based Health Caravan and Preventive Health Screening
    d. Comprehensive Eye Check-up and Provision of Free Prescription Glasses for Eligible Learners up to 15 yo.
    e. Medical Referral and Follow-up, when indicated

4. The proposed program shall be implemented **per school within each identified Municipality**, in coordination with the Schools Division Office, Public Schools District Office, School Heads, School Health Personnel, Teachers, Parents/ Guardians, and Other Designated DepEd Representatives.

    Identified Municipalities:
    - Municipality of Calumpit

- Municipality of Balagtas
- Municipality of Guiguinto
- Municipality of Plaridel
- Municipality of Pulilan
- Municipality of Paombong
- Municipality of Hagonoy

5. See attached annexes for your reference:

Annex A: Learners Package, Laboratory Exams Upon Request of Primary Care Physician, and List of Medicines under Philhealth GAMOT
Annex B: What is Philhealth YAKAP?
Annex C: What is Philhealth GAMOT?
Annex C: How to Register?
Annex D: Philhealth Konsulta Registration Form
Annex E: Philhealth Member Registration Form

6. Immediate dissemination of this Memorandum is desired.

[redacted]

CECILIA E. VALDERAMA, PhD, CESO VI
Schools Division Superintendent [redacted]

Annex A: Learners Package, Laboratory Exams Upon Request of Primary Care Physician, and List of Medicines under Philhealth GAMOT

Learners Package:

	Particular	PhilHealth YAKAP Member
1	Consult	FREE
2	Chest X-ray	
3	Eye Exam and Prescription Glasses (If needed)	
4	GAMOT	

Upon request of Primary Care Physician :

	Particular	PhilHealth YAKAP Member
1	CBC	FREE
2	Fecalysis	
3	Urinalysis	

List of Medicines under Philhealth GAMOT:

YAKAP	GAMOT
Amoxicillin	Albendazole
Ciprofloxacin	Azithromycin
Clarithoromycin	Cefixime
Co-amoxiclav	Clindamycin
Co-trimoxazole	Clotrimazole
Nitrofurantoin	Cloxacillin
Aspirin	Doxycycline
Fluticasone + Salmeterol	Erythromycin
Prednisone	Fluconazole
Salbutamol	Ketoconazole
Simvastatin	Metronidazole
Chlorphenamine	Oseltamivir
Oral Rehydration Salts	Tobramycin
Paracetamol	Clopidogrel
Gliclazide	Budesonide + Formoterol
Metformin	Ipratropium

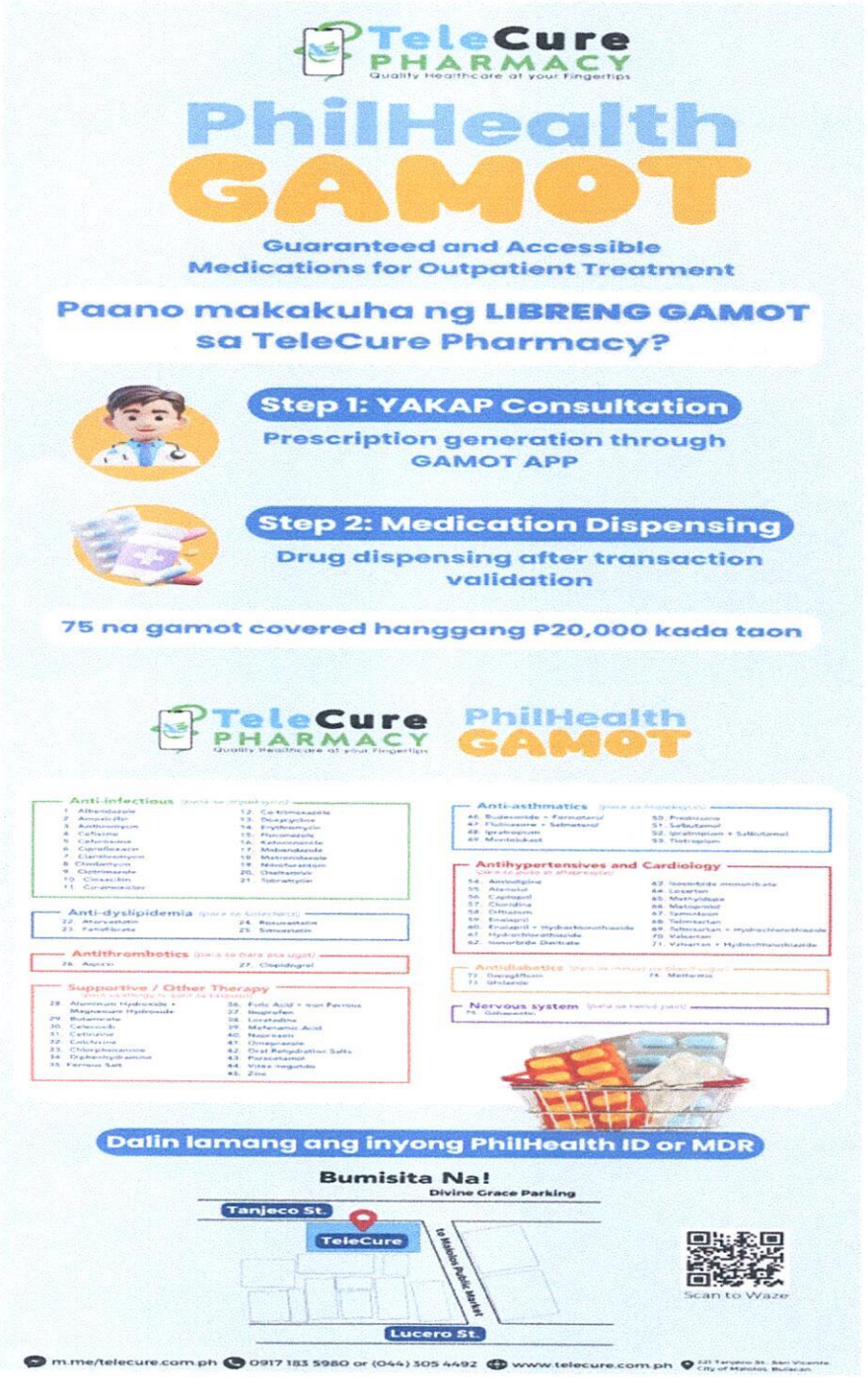
Amlodipine	Montelukast
Enalapril	Ipratropium + Salbutamol
Hydrochlorothiazide	Tiotropium
Losartan	Aluminum Hydroxide + Magnesium Hydroxide
Metoprolol	Butamirate
	Celecoxib
	Ceterizine
	Colchicine
	Diphenhydramine
	Ferrous Salt (Iron Preparations)
	Folic acid + Iron Ferrous
	Ibuprofen
	Lagundi (Vitex Negundo)
	Loratadine
	Mefanamic Acid
	Naproxen
	Omeprazole
	Zinc
	Dapagliflozin
	Atorvastatin
	Fenofibrate
	Rosuvastatin
	Atenolol
	Captopril
	Clonidine
	Diltiazem
	Enalapril + Hydrochlorothiazide
	Isosorbide Dinitrate
	Isosorbide Mononitrate
	Methyldopa
	Tamsulosin
	Telmisartan

	Telmoisartan + Hydrochlorothiazide
	Valsartan
	Valsartan + Hydrochlorothiazide
	Gabapentin

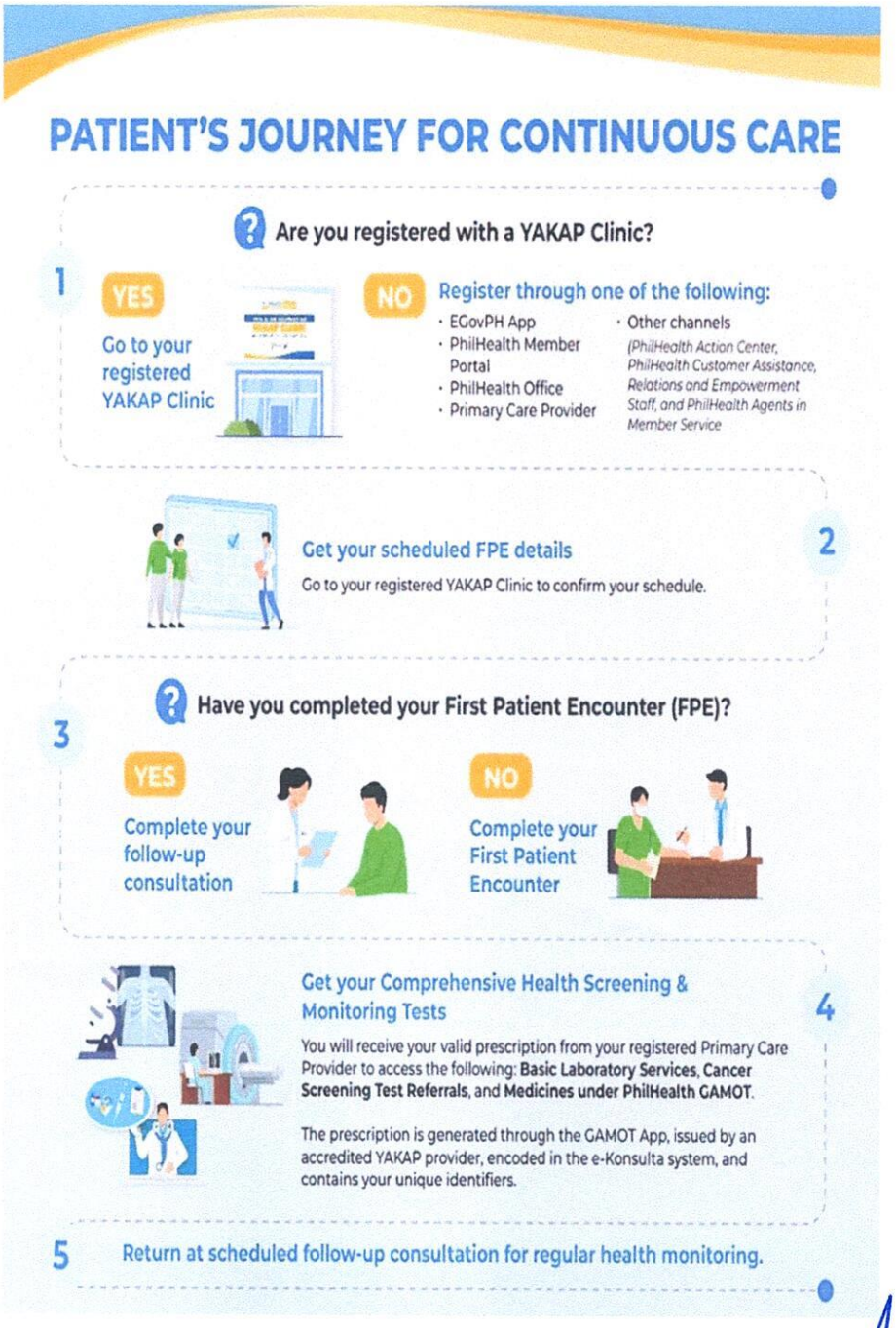
Annex B: What is Philhealth YAKAP?



Annex C: What is Philhealth GAMOT?



Annex D: How to Register?



Annex E: Philhealth Konsulta Registration Form

PhilHealth Konsulta Registration Form (PKRF)

INSTRUCTIONS

1. All information should be written in UPPER CASE/CAPITAL LETTER.
2. All fields are mandatory.
3. If the beneficiary is dependent, use the dependent PIN.
4. If the beneficiary is below 21 years old, the signatory should be the parent/guardian.

TO BE FILLED-OUT BY THE BENEFICIARY

☐ MEMBER ☐ DEPENDENT

PIN: _____ DATE: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

DATE OF BIRTH: _____ (MM/DD/YYYY) CONTACT NO: _____

☐ REGISTER TO A KONSULTA PACKAGE PROVIDER (KPP)

☐ REGISTER ALL MY DECLARED MINOR DEPENDENTS
(please use additional form if necessary)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

1ST CHOICE KPP: TELECURE MEDICAL AND DIAGNOSTIC CENTER

ADDRESS: SAN VICENTE (POB.), CITY OF MALOLOS, BULACAN (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

☐ TRANSFER

PREVIOUS KPP: _____

1ST CHOICE KPP: TELECURE MEDICAL AND DIAGNOSTIC CENTER

ADDRESS: SAN VICENTE (POB.), CITY OF MALOLOS, BULACAN (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

2ND CHOICE KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

I hereby certify that I did not avail of FPE in other KPP. Moreover, I grant my free and voluntary consent to the collection, transmission and processing of my personal data and health records to PhilHealth for the purpose of paying and monitoring the provider for the Konsulta benefit in accordance with Republic Act No. 10173, otherwise known as the "Data Privacy Act of 2012".

_____
(Signature over Printed Name)

PHILHEALTH'S COPY

TO BE FILLED-OUT BY PHILHEALTH KONSULTA PERSONNEL

PHILHEALTH KONSULTA REGISTRATION CONFIRMATION SLIP

REGISTRATION NO.: _____ DATE REGISTERED: _____ (MM/DD/YYYY)

FULL NAME: _____ (LAST NAME / FIRST NAME / MIDDLE NAME)

PIN: _____ DATE OF BIRTH: _____ (MM/DD/YYYY)

KPP: _____

ADDRESS: _____ (BARANGAY/TOWN / MUNICIPALITY/CITY / PROVINCE)

_____
(Signature over Printed Name of Authorized Personnel)

BENEFICIARY'S COPY

Republic of the Philippines
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Annex F: Philhealth Member Registration Form

PhilHealth
Your Partner in Health

PMRF
PHILHEALTH MEMBER REGISTRATION FORM
UHC v.1 January 2020

✓PHILHEALTH IDENTIFICATION NUMBER (PIN)

REMINDERS:

1. Your PhilHealth Identification Number (PIN) is your unique and permanent number.
2. Always use your PIN in all transactions with PhilHealth.
3. For Updating/Amendment check the appropriate box and provide details to be accomplished and submit corresponding supporting documents.
4. Please read instructions at the back before filling-out this form.

PURPOSE:
☐ REGISTRATION ☐ UPDATING/AMENDMENT

Preferred KonSulTa Provider
TELECURE MEDICAL AND DIAGNOSTIC CENTER

I. PERSONAL DETAILS

	LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	NO MIDDLE NAME (Check if applicable only)	MONONYM (Check if applicable only)
✓MEMBER					☐	☐
✓MOTHER's MAIDEN NAME					☐	☐
✓SPOUSE (If Married)					☐	☐

✓DATE OF BIRTH (m m d d y y y y)

✓PLACE OF BIRTH (City/Municipality/Province/Country)
(Please indicate country if born outside the Philippines)

PHILSYS ID NUMBER (Optional)

✓SEX
☐ Male ☐ Female

✓CIVIL STATUS
☐ Single ☐ Annulled ☐ Widow/er ☐ Married ☐ Legally Separated

✓CITIZENSHIP
☐ FILIPINO ☐ FOREIGN NATIONAL ☐ DUAL CITIZEN

TAX PAYER IDENTIFICATION NUMBER (TIN) (Optional)

II. ADDRESS and CONTACT DETAILS

✓PERMANENT HOME ADDRESS
Unit/Room No./Floor Building Name Lot/Block/Phase/House Number Street Name
Subdivision Barangay Municipality/City Province/State/Country (If abroad) ZIP Code

MAILING ADDRESS ☐ SAME AS ABOVE
Unit/Room No./Floor Building Name Lot/Block/Phase/House Number Street Name
Subdivision Barangay Municipality/City Province/State/Country (If abroad) ZIP Code

Home Phone Number
(COUNTRY CODE + AREA CODE + TELEPHONE NUMBER)
✓Mobile Number (Required)
Business (Direct Line)
E-mail Address (Required for OFW)

III. DECLARATION OF DEPENDENTS
(Use additional form if necessary)

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME	RELATIONSHIP	DATE OF BIRTH (mm-dd-yyyy)	CITIZENSHIP	NO MIDDLE NAME (Check if applicable only)	MONONYM (Check if applicable only)	Check if with Permanent Disability
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐
							☐	☐	☐

IV. MEMBER TYPE

DIRECT CONTRIBUTOR
☐ Employed Private
☐ Employed Government
☐ Professional Practitioner
☐ Self-Earning Individual
  ☐ Individual
  ☐ Sole Proprietor
  ☐ Group Enrollment Scheme
  _____
☐ Kasambahay
☐ Migrant Worker
  ☐ Land-Based ☐ Sea-Based
☐ Lifetime Member
☐ Filipinos with Dual Citizenship / Living Abroad
☐ Foreign National
  PRA SRRV No. _____
  ACR I-Card No. _____
☐ Family Driver

INDIRECT CONTRIBUTOR
☐ Listahanan
☐ 4Ps/MCCT
☐ Senior Citizen
☐ PAMANA
☐ KIA/KIPO
☐ Bangsamoro/Normalization
☐ LGU-sponsored
☐ NGA-sponsored
☐ Private-sponsored
☐ Person with Disability
PWD ID No. _____

PROFESSION: (Except Employed, Lifetime Members and Sea-based Migrant Worker)

✓MONTHLY INCOME:

PROOF OF INCOME:

For PhilHealth Use only:
☐ Point of Service (POS) Financially Incapable
☐ Financially Incapable

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Continue at the back

V. UPDATING/AMENDMENT		
Please check:	**FROM**	**TO**
☐ Change/Correction of Name (Last Name, First Name, Name Extension (Jr./Sr./III) Middle Name)		
☐ Correction of Date of Birth		
☐ Correction of Sex		
☐ Change of Civil Status		
☐ Updating of Personal Information/Address/ Telephone Number/Mobile Number/e-mail Address		

Under penalty of law, I hereby attest that the information provided, including the documents I have attached to this form, are true and accurate to the best of my knowledge. I agree and authorize PhilHealth for the subsequent validation, verification and for other data sharing purposes only under the following circumstances:

- As necessary for the proper execution of processes related to the legitimate and declared purpose;
- The use or disclosure is reasonably necessary, required or authorized by or under the law; and,
- Adequate security measures are employed to protect my information.

Please affix right thumbmark if unable to write

√Member's Signature over Printed Name

√Date

FOR PHILHEALTH USE ONLY

RECEIVED BY:

Full Name: _____

PRO/LHIO/Branch: _____

Date & Time: _____

INSTRUCTIONS

1. All information should be written in UPPER CASE/CAPITAL LETTERS. If the information is not applicable, write "N/A."
2. All fields are mandatory unless indicated as optional. By affixing your signature, you certify the truthfulness and accuracy of all information provided.
3. A properly accomplished PMRF shall be accompanied by a valid proof of identity for first time registrants, and supporting documents to establish relationship between member and dependent/s for updating or request for amendment.
4. On the PURPOSE, check the appropriate box if for **Registration** or for **Updating/Amendment** of information.
5. Indicate preferred KonSulTa provider near the place of work or residence.
6. For PERSONAL DETAILS, all name entries should follow the format given below. Check the appropriate box if registrant has no middle name and/or with single name (mononym).

LAST NAME	FIRST NAME	NAME EXTENSION (Jr./Sr./III)	MIDDLE NAME
SANTOS	JUAN ANDRES	III	DELA CRUZ

7. Indicate registrant's/member's name as it appears in the birth certificate.
8. The full mother's maiden name of registrant/member must be indicated as it appears in the birth certificate.
9. Indicate the full name of spouse if registrant/member is married.
10. Indicate the complete permanent and mailing addresses and contact numbers.
11. For updating/amendment, check the appropriate box to be updated/amended and indicate the correct data.
12. For MEMBER TYPE, check the appropriate box which best describes your current membership status.
13. For Direct Contributors, except employed, sea-based migrant workers and lifetime members, indicate the profession, monthly income and proof of income to be submitted.
14. For Self-earning individuals, Kasambahays and Family Drivers, indicate the actual monthly income in the space provided.
15. In declaring dependents, provide the full name of the living spouse, children below 21 years old, and parents who are 60 years old and above totally dependent to the member.
16. Dependents with disability shall be registered as principal members in accordance with Republic Act 11228 on mandatory PhilHealth coverage for all persons with disability (PWD).
17. The registrant must affix his/her signature over printed name (or right thumbmark if unable to write) and indicate the date when the PMRF was signed.