



Republic of the Philippines  
**Department of Education**  
Region II – Cagayan Valley  
SCHOOLS DIVISION OF NUEVA VIZCAYA

January 26, 2026

**DIVISION MEMORANDUM**

No. 35 s. 2026

**DIVISION KICK-OFF ACTIVITY FOR PROJECT OCULUS**

To: Assistant Schools Division Superintendent  
Chief-School Governance Operations Division  
Chief-Curriculum Implementation Division  
All Others Concerned

1. In line with the Department of Education's commitment to deliver inclusive, accessible, and equitable quality education, the Department of Education Regional Office II, through the Education Support Services Division – School Health and Nutrition Unit (ESSD-SHNU), in partnership with the Philippine Academy of Ophthalmology – Northeastern Luzon Chapter (PAO-NEL), is implementing **Project OCULUS: Ocular Check-up to Uncover Learners' Unseen Sight Gaps**.

2. Project OCULUS is a school-based health initiative that aims to strengthen the early detection and management of color vision deficiencies among learners. Specifically, it targets Grade 7 learners for color vision screening, promotes awareness on Color Vision Deficiency (CVD), and provides recommendations for appropriate learning support and accommodations to ensure that no learner is left unseen.

3. Following the successful Regional Kick-Off Activity of Project OCULUS held on October 17, 2025 at Libag Integrated School, Tuguegarao City, the Schools Division Office of Nueva Vizcaya, through the School Health and Nutrition Unit (SHNU), shall conduct a **Division Kick-Off Activity** to formally launch the implementation of Project OCULUS in all schools within the division.

4. The Division Kick-Off Activity shall be conducted on the following schedules and venues:

- a. **February 9, 2026 (Monday) – Afternoon**  
**Venue: Tiblac National High School, Ambaguio, Nueva Vizcaya**
- b. **February 13, 2026 (Friday) – Morning**  
**Venue: Casat National High School, Bayombong, Nueva Vizcaya**

5. The activity shall be graced and facilitated by invited guest doctors:

- a. **Dr. Tricia Katrina Allas**
- b. **Dr. Ethel Mauricio**
- c. **Dr. Nestor Tiongson**



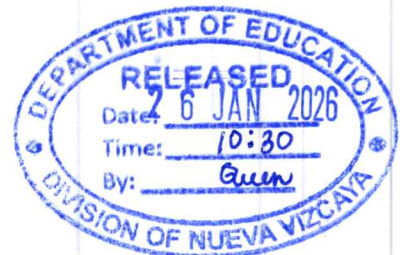
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6. To ensure the smooth implementation of the activity, designated nurses from the Schools Division Office of Nueva Vizcaya are hereby assigned to provide medical and technical support during each kick-off session.
7. All school heads are directed to ensure the participation of designated teaching and non-teaching personnel from their respective schools. Further details on participant allocation and program flow shall be issued through separate communication.
8. Expenses relative to the conduct of this activity shall be charged against available division or school funds, subject to existing accounting and auditing rules and regulations.
9. Attached herewith, is the Data Privacy Notice and Consent Form for your reference.
10. For further queries, kindly contact **Ryan Christopher A. Buccat, MD, Medical Officer III at 09275463220**
11. Immediate dissemination and strict compliance with this memorandum is enjoined.

**ORLANDO E. MANUEL PhD., CESO V**  
Schools Division Superintendent



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**SCHOOL HEALTH AND NUTRITION UNIT SDO NUEVA VIZCAYA**

NAME	OCULUS SCHEDULE
Ryan Christopher A. Buccat, MD Hazel B. Arreo, RN Lovelyn C. Cambaliza, RN Icarus S. Canam, RN Wilson D. Hindac, RN Julius Michael R. Panganiban, RN Tricia Maria C. Pascua, RN Marilou C. Roderos, RN Jennifer D. Sano, RN Herminia B. Basilio, RN Florence L. Bulayo, RN Jonalyn B. Panis, RN Bernette Ann R. Sebbey, RN	February 9, 2026 (Monday) – Afternoon Venue: Tiblac National High School, Ambaguio, Nueva Vizcaya
Ryan Christopher A. Buccat, MD Rudy S. Agustin, RN Ben Clarion R. Llantada, RN Sigrid Aleli M. Taipan, RN Shiela S. Zapata, RN Rannylene May T. De Leon, RN Mary-Ann E. Cabangon, RN Trixia Maureen D. Cabatin, RN Shairuz Caesar B. Dugay, RN Mignonette Erim O. Dulay, RN Karen Ann C. Gregorio Elvie A. Sanchez, RN Ali A. Vilar, RN	February 13, 2026 (Friday) – Morning Venue: Casat National High School, Bayombong, Nueva Vizcaya





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**DATA PRIVACY NOTICE AND CONSENT FORM**

**NOTIFICATION LETTER**

DATE: \_\_\_\_\_

DIVISION: \_\_\_\_\_  
SCHOOL: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

Dear Parent/Guardian:

This school will provide **Color Vision Screening to Grade 7 Learners** in coordination with the **Philippine Academy of Ophthalmology, Northeastern Luzon Chapter**.

This Notification is being issued to you as information of the activity that will be conducted for SY 2025 – 2026. Should you have further questions / clarifications on this matter, please get in touch with the Principal / School Head.

Thank you very much.

Very truly yours,

\_\_\_\_\_  
Name of School Head / Principal

**ACKNOWLEDGEMENT AND CONSENT**

Name of the Child			Date of Birth (mm/dd/yyyy)	
Surname:	First Name:	Middle Name:	/ /	
<b>Contact Information</b>			<b>Age</b>	<b>Sex</b>
Contact Number:	School:			

**DATA PRIVACY NOTICE**

*We would like your informed consent to hold personal data that you provide to us. All such personal data will be treated by us as strictly confidential.*

Please CHECK. the appropriate boxes if you agree	YES	NO
1. I agree to disclose my child's personal information necessary for the Color Vision Screening		
2. I agree to the collection and/ or processing of my child's personal information and data in accordance with the provisions of Republic Act No. 10173 otherwise known as the Data Privacy Act of 2012 and its Implementing Rules and Regulations, including related National Privacy Commission (NPC) issuances.		
3. I agree to give my consent for my child's color vision test result to be disclosed to me and my child, by DepEd Authorized Health personnel in coordination with the Division Guidance Counselor/Designate and/or Psychologist.		
4. I understand that this information will be treated with strict confidentiality and use solely for the purpose of supporting my child's educational and developmental needs.		

**CONSENT FOR COLOR VISION SCREENING**

- ☐ Yes, I will allow my child to undergo Color Vision Screening by Ophthalmologist/Trained Health Personnel
- ☐ No, I will not allow my child to undergo Color Vision Screening by Ophthalmologist/Trained Health Personnel  
Because: \_\_\_\_\_

By signing this waiver, I acknowledge that I have read and understood the information provided above.

\_\_\_\_\_  
Name and Signature of Parent / Guardian