附件1

**浙江省申请教师资格人员体格检查表**

(2010年12月修订)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 身份证号码 | |  |  |  |  |  | |  | |  | |  | |  | |  |  | |  | | |  | |  | |  |  |  |  | 一寸照片 |
| 姓 名 | |  | | | | | | | | | | | | | | | 主检医师意见:  签名： | | | | | | | | | | | | |
| 性别 |  | 出生年月 | | |  | | | | | | | | | | | |
| 既往病史 | 1.肝炎 2.结核 3.皮肤病4.性传播性疾病  5.精神病 6.其他：  受检者确认签字： | | | | | | | | | | | | | | | |
| 眼  科 | 裸眼视力 | 左： | | | | | 矫正视力 | | | | 左：矫正度数 | | | | | | | | | | | | | 检查者 | | | | | | 医师意见：  签名： |
| 右： | | | | | 右：矫正度数 | | | | | | | | | | | | |
| 色觉  检查 | 彩色图案及彩色数码检查：  色觉检查图名称：  单色识别能力检查：(色觉异常者查此项)  红( ) 黄( ) 绿( ) 蓝( ) 紫( ) | | | | | | | | | | | | | | | | | | | | | | 检查者 | | | | | |
| 眼病 | |  | | | | | | | | | | | | | | | | | | | | |
| 内  科 | 血压 | | / Kpa | | | | | | | | | | | | | | | | | | 检查者 | | | | | | | | | 医师意见：  签名： |
| 发育情况 | |  | | | | | | | | | | 心脏及血管 | | | | | | | |  | | | | | | | | |
| 呼吸系统 | |  | | | | | | | | | | 神经系统 | | | | | | | |  | | | | | | | | |
| 腹部器官 | | 肝 脾 肾 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 其它 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 外  科 | 身高 | | 厘米 | | | | | | | 体重 | | | | | 千克 | | | | | | | | 颈部 | | | |  | | | 医师意见：  签名： |
| 皮肤 | |  | | | | | | | 面部 | | | | |  | | | | | | | | 关节 | | | |  | | |
| 脊柱 | |  | | | | | | | 四肢 | | | | |  | | | | | | | | 检查者 | | | | | | |
| 其它 | |  | | | | | | | | | | | | | | | | | | | |
| 耳  鼻  喉 | 听力 | | 左耳 米 | | | | | | 右耳 米 | | | | | | | | 检查者 | | | | | |  | | | | | | | 医师意见：  签名： |
| 嗅觉 | |  | | | | | | | | | | | | | | 检查者 | | | | | |  | | | | | | |
| 耳鼻咽喉 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 口  腔  科 | 唇腭 | |  | | | | | | | | | | | | | | | | | 是否口吃 | | | | |  | | | | | 医师意见：  签名： |
| 牙齿 | | (齿缺失————— + ——————) | | | | | | | | | | | | | | | | |
| 其它 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 胸部透视 医师签名： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 肝脏功能 |  | | | | | | | | | | | | | | | | | 体  检  结  论 | | | | | 主检医师签名：  年 月 日(医院盖章) | | | | | | | |
| 主检医师意见：  签名： | | | | | | | | | | | | | | | | | |

说明：1．“既往病史”一栏，申请人必须如实填写，如发现有隐瞒严重病史，不符合认定条件者，

即使取得资格，一经发现收回认定资格。

2．主检医师作体检结论要填写合格、不合格两种结论，并简单说明原因。

**浙江省申请幼儿园教师资格人员体格检查表**

(2010年12月制定)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 身份证号码 | |  |  |  |  |  | |  | |  | |  | |  | |  | |  | |  | | |  | |  | |  | |  |  |  | 一寸照片 | |
| 姓 名 | |  | | | | | | | | | | | | | | | | 主检医师意见:  签名： | | | | | | | | | | | | | |
| 性别 |  | 出生年月 | | |  | | | | | | | | | | | | |
| 既往病史 | 1.肝炎 2.结核 3.皮肤病4.性传播性疾病  5.精神病 6.其他：  受检者确认签字： | | | | | | | | | | | | | | | | |
| 眼  科 | 裸眼视力 | 左： | | | | | 矫正视力 | | | | 左：矫正度数 | | | | | | | | | | | | | | 检查者 | | | | | | | 医师意见：  签名： | |
| 右： | | | | | 右：矫正度数 | | | | | | | | | | | | | |
| 色觉  检查 | 彩色图案及彩色数码检查：  色觉检查图名称：  单色识别能力检查：(色觉异常者查此项)  红( ) 黄( ) 绿( ) 蓝( ) 紫( ) | | | | | | | | | | | | | | | | | | | | | | | 检查者 | | | | | | |
| 眼病 | |  | | | | | | | | | | | | | | | | | | | | | |
| 内  科 | 血压 | | / Kpa | | | | | | | | | | | | | | | | | | | 检查者 | | | | | | | | | | 医师意见：  签名： | |
| 发育情况 | |  | | | | | | | | | | 心脏及血管 | | | | | | | | |  | | | | | | | | | |
| 呼吸系统 | |  | | | | | | | | | | 神经系统 | | | | | | | | |  | | | | | | | | | |
| 腹部器官 | | 肝 脾 肾 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 其它 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 外  科 | 身高 | | 厘米 | | | | | | | 体重 | | | | | 千克 | | | | | | | | | 颈部 | | | | |  | | | 医师意见：  签名： | |
| 皮肤 | |  | | | | | | | 面部 | | | | |  | | | | | | | | | 关节 | | | | |  | | |
| 脊柱 | |  | | | | | | | 四肢 | | | | |  | | | | | | | | | 检查者 | | | | | | | |
| 其它 | |  | | | | | | | | | | | | | | | | | | | | |
| 耳  鼻  喉 | 听力 | | 左耳 米 | | | | | | 右耳 米 | | | | | | | | | 检查者 | | | | | |  | | | | | | | | 医师意见：  签名： | |
| 嗅觉 | |  | | | | | | | | | | | | | | | 检查者 | | | | | |  | | | | | | | |
| 耳鼻咽喉 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 口  腔  科 | 唇腭 | |  | | | | | | | | | | | | | | | | | | 是否口吃 | | | | |  | | | | | | 医师意见：  签名： | |
| 牙齿 | | (齿缺失————— + ——————) | | | | | | | | | | | | | | | | | |
| 其它 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 胸部透视 医师签名： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 化验检查 | 丙氨酸氨基转移酶(ALT) | | | | | | | |  | | | | | | | | 滴虫 | | | | | | | | | | |  | | | | | 检查者 |
| 淋球菌 | | | | | | | |  | | | | | | | | 梅毒螺旋体 | | | | | | | | | | |  | | | | |
| 外阴阴道假丝酵母菌(念珠菌) | | | | | | | |  | | | | | | | | 其他 | | | | | | | | | | |  | | | | |
| 肝脏功能 |  | | | | | | | | | | | | | | | | | | 体  检  结  论 | | | | | 主检医师签名：  年 月 日(医院盖章) | | | | | | | | | |
| 主检医师意见：  签名： | | | | | | | | | | | | | | | | | | |

说明：1．“既往病史”一栏，申请人必须如实填写，如发现有隐瞒严重病史，不符合认定条件者，

即使取得资格，一经发现收回认定资格。滴虫、外阴阴道假丝酵母菌指妇科检查项目。

2．主检医师作体检结论要填写合格、不合格两种结论，并简单说明原因。