**联系电话: 教师资格种类：幼儿园 体检号：**

**浙江省申请幼儿园教师资格人员体格检查表（金东区）**

**（2010年12月制定）**

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| **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** | | | **右：** | | | | | | **矫正视力** | | | | | | **右：矫正度数** | | | | | | | | | | | | | | | **检查者** | | | | | | | **医师意见：**  **签名：** | |
| **左：** | | | | | | **左：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** | | | | **/ mmHg** | | | | | | | | | | | | | | | | | | | | | | **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。**

1. **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。**

**联系电话: 教师资格种类：小学 体检号：**

**浙江省申请教师资格人员体格检查表（金东区）**

**（2010年12月修订）**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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** | | | |  | | | | | | | | | | |
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| **左：** | | | | | | **左：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** | | | | **/ mmHg** | | | | | | | | | | | | | | | | | | | | | **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** | | | | | | | |  | | | | | | | | | | |
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| **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）** | | | | | | | | | | | | | |
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**（2010年12月修订）**

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| **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** | | | |  | | | | | | | | | | |
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| **眼病** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **内科** | **血压** | | | | **/ mmHg** | | | | | | | | | | | | | | | | | | | | | **检查者** | | | | | | | | | | | **医师意见：**  **签名：** |
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| **呼吸系统** | | | |  | | | | | | | | | | | | | **神经系统** | | | | | | | |  | | | | | | | | | | |
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| **其它** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **外科** | **身高** | | | | **厘米** | | | | | | | | **体重** | | | | | **千克** | | | | | | | | | | **颈部** | | | | |  | | | | **医师意见：**  **签名：** |
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| **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）** | | | | | | | | | | | | | |
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