浙江省申请教师资格人员体格检查表

所在县（市、区）：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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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 | | | | / 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。