安徽省教师资格申请人员体检表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 |  | 年龄 | |  | | | | 性别 |  | | | 婚否 | |  | 民族 | |  | 相 片 |
| 申报学科 |  | 身份证号 | | |  | | | | | | | 联系电话 | |  | | | |
| 既往病史（本人  如实填写） | |  | | | | | | | | | | | | | | | |
| 体检结论 | | 负责医师签字： | | | | | | | | | | | | | | | | |
| 体检医院  意 见 | | 体检医院公章  年 月 日 | | | | | | | | | | | | | | | | |
| 五  官  科 | 裸眼视力 | 右 | | | | | 矫正视力 | | | 右 | | | | 矫正度数 | | 右 | | 医师意见：  签名： |
| 左 | | | | | 左 | | | | 左 | |
| 辨色力 |  | | | | | | | | 眼病 | | | |  | | | |
| 听力 | 左耳 米 | | | | | | | | | 右耳 米 | | | | | | |
| 鼻 | 嗅觉 | | | |  | | | 鼻及鼻窦 | | | |  | | | | |
| 面部 |  | | | | | | | 咽喉 | | | |  | | | | |
| 口腔唇腭 |  | | | | | | | 齿 | | | |  | | | | |
| 其它 |  | | | | | | | | | | | | | | | |
| 外  科 | 身高 | Cm | | | | | | | 体重 | | | | Kg | | | | | 医师意见：  签名： |
| 淋巴 |  | | | | | | | 脊柱 | | | |  | | | | |
| 四肢 |  | | | | | | | 关节 | | | |  | | | | |
| 皮肤 |  | | | | | | | 颈部 | | | |  | | | | |
| 其它 |  | | | | | | | | | | | | | | | |
| 内  科 | 营养状况 | |  | | | | | | | | | | | | | | | 医师意见：  签名： |
| 血 压 | |  | | | | | | | | | | | | | | |
| 心脏及血管 | |  | | | | | | | | | | | | | | |
| 呼吸系统 | |  | | | | | | | | | | | | | | |
| 腹部器官 | |  | | | | | | | | | | | | | | |
| 神经及精神 | |  | | | | | | | | | | | | | | |
| 其它 | |  | | | | | | | | | | | | | | |
| 心 电 图 | | |  | | | | | | | | | | | | | | | 签名： |
| 实  验  室  检  查 | 血常规 | |  | | | | | | | | | | | | | | | 签名： |
| 尿常规 | |  | | | | | | | | | | | | | | | 签名： |
| 转氨酶 | |  | | | | | | | | | | | | | | | 签名： |
| 胸 部 透 视 | | |  | | | | | | | | | | | | | | | 签名： |

说明：1.申请人个人基本信息由本人填写完整，照片可以由体检医院现场拍摄，也可自行粘贴一寸照片；

2.负责医师作体检结论要填写“合格” 、“不合格“两种结论，并说明原因，签字或签章；

3.体检中心需加盖公章、写明体检日期。

安徽省教师资格申请人员体检表（幼儿园）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 |  | | 年龄 |  | | | | | 性别 |  | | | 婚否 | |  | 民族 | |  | 相片 |
| 籍贯 |  | | 身份证号 | | | | |  | | | | | | | 联系电话 | |  | |
| 既往病史（本人  如实填写） | | | 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： | | | | | | | | | | | | | | | |
| 体检结论 | | | 负责医师签字： | | | | | | | | | | | | | | | | |
| 体检医院  意见 | | | 体检医院公章  年 月 日 | | | | | | | | | | | | | | | | |
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| 左 | | | | 左 | | | | 左 | |
| 辨色力 | |  | | | | | | | | 眼病 | | | |  | | | |
| 听力 | | 左耳 米 | | | | | | | | | 右耳 米 | | | | | | |
| 鼻 | | 嗅觉 | | |  | | | | 鼻及鼻窦 | | | |  | | | | |
| 面部 | |  | | | | | | | 咽喉 | | | |  | | | | |
| 口腔唇腭 | |  | | | | | | | 齿 | | | |  | | | | |
| 其它 | |  | | | | | | | | | | | | | | | |
| 外  科 | 身高 | | 米 | | | | | | | 体重 | | | | 公斤 | | | | | 医师意见：  签名： |
| 淋巴 | |  | | | | | | | 脊柱 | | | |  | | | | |
| 四肢 | |  | | | | | | | 关节 | | | |  | | | | |
| 皮肤 | |  | | | | | | | 颈部 | | | |  | | | | |
| 其它 | |  | | | | | | | | | | | | | | | |
| 内  科 | 营养状况 | | | |  | | | | | | | | | | | | | | 医师意见：  签名： |
| 血压 | | | |  | | | | | | | | | | | | | |
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| 腹部器官 | | | |  | | | | | | | | | | | | | |
| 神经及精神 | | | |  | | | | | | | | | | | | | |
| 其它 | | | |  | | | | | | | | | | | | | |
| 心电图 | | | | |  | | | | | | | | | | | | | | 签名： |
| 妇科检查 | | 滴虫 | | |  | | | | | | | | | | | | | | 签名： |
| 外阴阴道假丝  酵母菌（念球菌） | | |  | | | | | | | | | | | | | |
| 实  验  室  检  查 | | 血常规 | | |  | | | | | | | | | | | | | | 签名： |
| 尿常规 | | |  | | | | | | | | | | | | | | 签名： |
| 转氨酶 | | |  | | | | | | | | | | | | | | 签名： |
| 淋球菌 | | |  | | | | | | | | | | | | | | 签名： |
| 梅毒螺旋体 | | |  | | | | | | | | | | | | | | 签名： |
| 胸部透视 | | | | |  | | | | | | | | | | | | | | 签名： |

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