附件2：

**申请教师资格人员体检表**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓 名 | | |  | | | | | | 性 别 | |  | | | 出 生 | | | | 年 月 日 | | | | | | | 半身一寸  脱帽照片  （教师资格认定办公室章） | |
| 身份证号 | | |  | | | | | | | | | | | 民 族 | | | |  | | | 婚 否 | | |  |
| 联系电话 | | |  | | | | | | 工作单位或  毕业学校 | | | | |  | | | | | | | | | | |
| 现住所及通讯地址 | | | | | |  | | | | | | | | | | | | | | | | | | |
| 既往病史 | | | 心脏病、肾炎、肝炎、关节炎、哮喘、精神病、癫痫、肺结核、胃病等  （ ） | | | | | | | | | | | | | | | | | | | | | | | |
| 以上由本人如实填写，学校及所在单位负责审核 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 五  官  科 | | 眼 | | 视力 | | | 左 | | | | | | | | | | | | 色盲 | | | |  | | 医师签字 | |
| 右 | | | | | | | | | | | |
| 矫正  视力 | | | 左 | | | | | | | | | | | | 其他  眼病 | | | |  | |
| 右 | | | | | | | | | | | |
| 耳 | | 听力 | | | 左 米 | | | | | | | | 耳 疾 | | | |  | | | | | | 医师签字 | |
| 右 米 | | | | | | | |
| 口鼻 | | 嗅觉 | | |  | | | | | 鼻及鼻窦 | | | | | | |  | | | | | |
| 口吃 | | |  | | | | | 咽喉 | | | | |  | | | | | | | |
| 唇颚 | | |  | | | | | 门齿 | | | | |  | | | | | | | |
| 颜面部 | | | | |  | | | | | 其他 | | | | |  | | | | | | | |
| 外  科 | | 身高 | | | 公分 | | | | | | | 体重 | | | | | 公斤 | | | | | | | | 医师签字 | |
| 淋巴 | | |  | | | | | | | 皮肤 | | | | |  | | | | | | | |
| 四肢 | | |  | | | | | | | 甲状腺 | | | | |  | | | | | | | |
| 关节 | | |  | | | | | | | 胸廓 | | | | |  | | | | | | | |
| 外貌  异常 | | |  | | | | | | | 脊柱 | | | | |  | | | | | | | |
| 平跖足 | | |  | | | | | | | 其它 | | | | |  | | | | | | | |
| 内  科 | 血压 | | | | | | | 千帕 毫米汞柱 | | | | | | | | | | | | | | | | | | 医师签字 |
| 心率（次/分） | | | | | | |  | | | | | | | | 发育及  营养状况 | | | |  | | | | | |
| 肺及呼吸道 | | | | | | |  | | | | | | | | | | | | | | | | | |  |
| 心脏 | | | | | | |  | | | | | | | | | | | | | | | | | |
| 腹部B超 | | | | | | | 肝 | |  | | | | | | | | | | | | | | | |
| 脾 | |  | | | | | | | | | | | | | | | |
| 神经及精神 | | | | | | |  | | | | | | | | | | | | | | | | | |
| 其他 | | | | | | |  | | | | | | | | | | | | | | | | | |
| 妇科检查 | | | | | | | |  | | | | | | | | | | | | | | | | | | 医师签字 |
| 心 电 图 | | | | | | | |  | | | | | | | | | | | | | | | | | | 医师签字 |
| 胸部透视 | | | | | | | |  | | | | | | | | | | | | | | | | | | 医师签字 |
| 化验检查  （另附外验单） | | | | | | | | 肝功 | | | | |  | | | 血糖 | | | | | |  | | | | 化验员签字 |
| 申请幼儿园  教师资格加测  （另附化验单） | | | | | | | | 淋球菌 | | | | |  | | | 梅毒螺旋体 | | | | | |  | | | | 化验员签字 |
| 滴虫 | | | | |  | | | 外阴道假丝酵母菌（念球菌） | | | | | |  | | | |
| 体检结论 | | | | | | | | （填写合格、不合格两种结论，不合格的要注明原因。） | | | | | | | | | | | | | | | | | | 负责医师  签 字 |
| 体检医院  意 见 | | | | | | | | 医院公章  20 年 月 日 | | | | | | | | | | | | | | | | | | |

说明：1.既往病史一栏，必须如真实填写，在病名上划 “√”，并在括号内写明患病时间，所在学校或单位负责审核。2.体检时须携带本人身份证。3.体检人员必须在教师资格认定机构规定的体检时间内空腹到指定医院参加体检。4.由于本人不按规定时间和要求进行检查，造成不能体检或体检项目不完整的视为体检不合格。5.如发现有隐瞒严重病史，不符合认定条件者，即使取得资格，一经发现取消教师资格。