幼儿园教师资格申请人员体检表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓名** | |  | | **年龄** |  | | | **性别** | | |  | | **婚否** | |  | | **民族** | |  | **相**    **片** |
| **籍贯** | |  | | **工 作**  **单 位** | | |  | | | | | | **联系**  **电话** | |  | | | | |
| **既 往 病 史**  **本 人 如 实 填 写** | | | | 受检者确认签字： | | | | | | | | | | | | | | | |
| **五**  **官**  **科** | **裸 眼**  **视 力** | | | **右** | | | **矫 正**  **视 力** | | | | **右** | | | **矫 正**  **度 数** | | | | **右** | | **签名** |
| **左** | | | **左** | | | **左** | |
| **辩 色 力** | | |  | | | | | | | | | | | | | | | | **签名** |
| **听 力** | | | **左 耳 米** | | | | | | | | **右 耳 米** | | | | | | | | **医师意见:**  **签名** |
| **鼻** | | | **嗅 觉** | |  | | | | | | **鼻及鼻窦** | | | | |  | | |
| **面 部** | | |  | | | | | | **咽 喉** | | | | |  | | | | |
| **口 腔**  **唇 腭** | | |  | | | | | | **牙齿** | | | | |  | | | | | **医师意见:**  **签名** |
| **是 否**  **口 吃** | | |  | | | | | | **发 音 是**  **否 嘶 哑** | | | | |  | | | | |
| **外**  **科** | **身 高** | | | **公分** | | | | | | **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** | | |  | | | | | | | | | | | | | | | |
| **心脏及血管** | | |  | | | | | | | | | | | | | | | |
| **呼吸系统** | | |  | | | | | | | | | | | | | | | |
| **腹部器官** | | |  | | | | | | | | | | | | | | | |
| **神经及精神** | | |  | | | | | | | | | | | | | | | |
| **其它** | | |  | | | | | | | | | | | | | | | |
| **化验检查** | **淋球菌** | | |  | | | | | **滴 虫** | | | | | | |  | | | | **签名** |
| **梅毒螺旋体** | | |  | | | | | **外阴阴道假丝酵母菌（念珠菌）** | | | | | | |  | | | |
| **胸 部 透 视** | | | |  | | | | | | | | | | | | | | | | **签名** |
| **粘 贴 报 告 单** | | | | | | | | | | | | | | | | | | | | |
| **体检结论** | | | **负责医师签名:** | | | | | | | | | | | | | | | | | |
| **体检意见** | | | **体检医院公章**  **年 月 日** | | | | | | | | | | | | | | | | | |

说明：1.“既往病史”指肝炎、结核、皮肤病、性传播性疾病、精神病和其他病史，受检者应如实填写，并签字确认；2.滴虫、外阴阴道假丝酵母菌（念珠菌）指妇科检查项目；3.对出现呼吸系统疑似症状者增加胸片检查项目。