附件2

福建省中小学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** | | |  | | | | | | | | | | |
| **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<,/B>** | | <,/o:p> | | | **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** | |  | | | | | | | | | | |
| **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** |

**省教育厅制（2006年）**

福建省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** | | | 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： | | | | | | | | | | | | | | | | | |
| **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。