**附件1**

**云南省申请认定教师资格人员体检表**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 |  | | | 年龄 | |  | | | 性别 | |  | | 婚否 | |  | | | | 民族 | |  | 相片 |
| 籍贯 |  | 常住地址 | | | |  | | | | | | | 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 | | | | 医师意见 |
| 左 | | | 左 | | | | 左 | | | |
| 辩色力 | | | |  | | | | | 眼病 | | | |  | | | | | | | | 签名 |
| 听 力 | | | | 左耳 米 | | | | | | 右耳 米 | | | | | | | | | | |
| 鼻 | | | | 嗅觉 | |  | | | | 鼻及鼻窦 | | | | | |  | | | | |
| 面部 | | | |  | | | | | | 咽喉 | | | | | |  | | | | |
| 口腔唇腭 | | | |  | | | | | | 齿 | | | | | |  | | | | |
| 其他 | | | |  | | | | | | | | | | | | | | | | |
| 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 | |  |
| 妇科检查 | |  | | 签名 |
| 胸部透视 | |  | | 签名 |
| 化验检查 | |  | | 签名 |
| 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 | | |

**云南省申请认定教师资格人员体检表**

**（参照样表）**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 | XXX | | | 年龄 | | XX | | | 性别 | | 男 | | 婚否 | | 否 | | | | 民族 | 汉族 | 相片 |
| 籍贯 | 元谋 | 常住地址 | | | | 楚雄市XX路XX号 | | | | | | | 联系电话 | | | | | | 13XXXXXXXXX | |
| 既往病史(本人如实填写) | | | 无 | | | | | | | | | | | | | | | | | |
| 五  官  科 | 裸 眼  视 力 | | | | 右 | | | 矫 正  视 力 | | 右 | | | | 矫 正  度 数 | | | | 右 | | | 医师意见 | |
| 左 | | | 左 | | | | 左 | | |
| 辩色力 | | | |  | | | | | 眼病 | | | |  | | | | | | | 签名 |
| 听 力 | | | | 左耳 米 | | | | | | 右耳 米 | | | | | | | | | |
| 鼻 | | | | 嗅觉 | |  | | | | 鼻及鼻窦 | | | | | |  | | | |
| 面部 | | | |  | | | | | | 咽喉 | | | | | |  | | | |
| 口腔唇腭 | | | |  | | | | | | 齿 | | | | | |  | | | |
| 其他 | | | |  | | | | | | | | | | | | | | | |
| 外  科 | 身 高 | | | | 公分 | | | | | | | 体 重 | | | | 公斤 | | | | | 医师意见  签名 |
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| 四 肢 | | | |  | | | | | | | 关 节 | | | |  | | | | |
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| 其它 | | | |  | | | | | | | | | | | | | | | |

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| 呼吸系统 | |  |
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| 化验检查 | |  | | 签名 |
| 体检结论 | | 合格  负责医师签字： | | |
| 体检医院  意 见 | | 合格  体检医院公章  年 月 日 | | |