附件2

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| 宁夏回族自治区申请教师资格人员体检表 | | | | | | | | | | | | | | | | | | |
| 姓名 |  | | | 年龄 | |  | | 性别 |  | | 婚否 |  | 民族 | | |  |  | |
| 籍贯 |  | | | 申请资格种类 | |  | | | 联系电话 | | |  | | | | | 相片 | |
| 既 往 病 史（如有病史，请在项目前□内打√） | | | | | | | | | | | | | | | | |  | |
| 请本人如实填写既往病史，如有隐瞒，由本人承担相应责任。 | | | | | | □严重肠胃疾病 □恶性肿瘤 □癫 痫 □精神病 □癔 症 | | | | | | | | | | | | |
| □晚期血吸虫病 □红斑狼疮 □心脏病 □肺结核 □糖尿病 | | | | | | | | | | | | |
| □类风湿性关节炎 □淋病、梅毒、艾滋病等 | | | | | | | | | | | | |
| 本人签字： | | |  |  | | □其他病史： | | | | | | | | | | | | |
| **以上栏目由申请人填写** | | | | | | | | | | | | | | | | | | |
| 五 官 科 | 裸眼视力 | | | 右 | |  | | | 矫正视力 | | | 右 | | |  | | 医师意见： | |
| 左 | |  | | | 左 | | |  | |  | |
| 辨色力 | | |  | | | | | 眼病 | | |  | | | | | 签名： | |
| 听力 | | | 左耳 米 | | | | | 右耳 米 | | | | | | | | 医师意见： | |
| 耳疾 | | |  | | | | | | | | | | | | |  | |
| 鼻 | | | 嗅 觉 | | | |  | 鼻及鼻窦 | | |  | | | | |  | |
| 面部 | | |  | | | | | 咽喉 | | |  | | | | |  | |
| 口腔唇腭 | | |  | | | | | 齿 | | |  | | | | |  | |
| 其他 | | |  | | | | | | | | | | | | | 签名： | |
| 内 科 | 血压 | | |  | | | | | 心脏及血管 | | |  | | | | | 医师意见： | |
| 呼吸系统 | | |  | | | | | 腹部器官 | | |  | | | | |  | |
| 其他 | | |  | | | | | | | | | | | | | 签名： | |
| 外 科 | 淋巴 | | |  | | | | | 脊柱 | | |  | | | | | 医师意见： | |
| 四肢 | | |  | | | | | 关节 | | |  | | | | |  | |
| 皮肤 | | |  | | | | | 颈部 | | |  | | | | |  | |
| 其他 | | |  | | | | | | | | | | | | | 签名： | |
| B超检查 | |  | | | | | | | | | | | | 医师意见： | | | |
| 签名： | | | |
| 放射科 | |  | | | | | | | | | | | | 医师意见： | | | |
| 签名： | | | |
| 心电图 | |  | | | | | | | | | | | | 医师意见： | | | |
| 签名： | | | |
| 肝功 | |  | | | | | | | | | | | | 医师意见： | | | |
| 签名： | | | |
| 申请幼儿园教师资格体检项目增加 | | 滴虫 | | | 念球菌 | | 淋球菌 | | | 梅毒螺旋体 | | | | 医师意见： | | | |
|  | | |  | |  | | |  | | | | 签名： | | | |
| 体检结论 | |  | | | | | | | | | | | | | | | |
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| 负责医生签名： | | | | | | | | | | | | | | | |
| 体检医院 意见 | |  | | | | | | | | | | | | | | | |
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| 体检负责人签名： | | |  | |  | | | 体检医院公章 | | | |  | | | |
|  | | |  | |  | | |  | | | | 年 月 日 | | | |