附件1

**健康体检须知**

**1．体检时间**：2023年6月 19 至 20 日，上午8：00开始（体检人请在上午9：30点前到达体检现场）。

**2．体检地点：**浙江鑫达医院健康管理中心（行政楼体检中心）

**3．注意事项：**

①体检前一日，晚清淡饮食、禁酒，晚8点后禁食，晚10点及次日晨禁水、禁食(可用少量白开水送服原服用药物，降血糖药除外)。

②体检当日，请携带好《浙江省申请教师资格人员体格检查表》及本人身份证到体检中心一楼签到，核对相关信息后按指引进行体检。

③肝功能项目须保持空腹，验血结束后方可进食。抽血后局部请按压5分钟，不要动，避免皮下出血。

④胸部摄片（DR）请不要穿戴有金属饰品等物的内衣，体检中心设有专属更衣室。

**4．报告送达：**体检结束后，将体检指引单交给体检中心二楼导检台工作人员。电子体检报告可以关于“浙江鑫达医院公众号”进行查询，纸质体检报告将由医院统一送达到吴兴区教师资格证办公室。

**5.咨询热线：0572- 2968916**（工作日8:00-11:30，13:30-16:30）

**6.具体地址：**浙江鑫达医院-湖州市南太湖新区鑫行渎港北路（鑫远.太湖健康城桃源居西侧）

**7.车辆停放：**浙江鑫达医院行政楼门口南门广场

**8.公交线路**：25路、62路、50路



附件2

浙江省申请中小学教师资格人员体格检查表

（2010年12月修订）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 身份证号码 | | | | |  |  | |  |  |  | |  | | |  | |  |  | |  | | |  |  | |  | |  | |  | | |  |  |  | 一寸照片 |
| 姓 名 | | | |  | | | | | | | | | | | | | | | | | 主检医师意见：  签名： | | | | | | | | | | | | | | |
| 性别 | |  | | 出生年月 | | | | |  | | | | | | | | | | | |
| 既往病史 | | 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： | | | | | | | | | | | | | | | | | | |
| 眼科 | 裸眼视力 | | | 右： | | | | | | | 矫正视力 | | | | | 右：矫正度数 | | | | | | | | | | | | | 检查者 | | | | | | | 医师意见：  签名： |
| 左： | | | | | | | 左：矫正度数 | | | | | | | | | | | | |
| 色觉检查 | | | | | | 彩色图案及彩色数码检查：  色觉检查图名称：  单色识别能力检查：（色觉异常者查此项）  红（ ） 黄（ ） 绿（ ） 蓝（ ） 紫（ ） | | | | | | | | | | | | | | | | | | | | | | 检查者 | | | | | | |
| 眼病 | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 内科 | 血压 | | | | | | / kpa | | | | | | | | | | | | | | | | | | 检查者 | | | | | | | | | | | 医师意见：  签名： |
| 发育情况 | | | | | |  | | | | | | | | | | | | 心脏及血管 | | | | | |  | | | | | | | | | | |
| 呼吸系统 | | | | | |  | | | | | | | | | | | | 神经系统 | | | | | |  | | | | | | | | | | |
| 腹部器官 | | | | | | 肝 脾 肾 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 其它 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 外科 | 身高 | | | | | | 厘米 | | | | | | | 体重 | | | | | 千克 | | | | | | | | 颈部 | | | |  | | | | | 医师意见：  签名： |
| 皮肤 | | | | | |  | | | | | | | 面部 | | | | |  | | | | | | | | 关节 | | | |  | | | | |
| 脊柱 | | | | | |  | | | | | | | 四肢 | | | | |  | | | | | | | | 检查者 | | | | | | | | |
| 其它 | | | | | |  | | | | | | | | | | | | | | | | | | | |
| 耳鼻喉 | 听力 | | | | | | 左耳 米 | | | | | | 右耳 米 | | | | | | | | | 检查者 | | | | |  | | | | | | | | | 医师意见：  签名： |
| 嗅觉 | | | | | |  | | | | | | | | | | | | | | | 检查者 | | | | |  | | | | | | | | |
| 耳鼻咽喉 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 口腔科 | 唇腭 | | | | | |  | | | | | | | | | | | | | | | | | | | | 是否口吃 | | | | |  | | | | 医师意见：  签名： |
| 牙齿 | | | | | | （齿缺失——————+——————） | | | | | | | | | | | | | | | | | | | |
| 其它 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 胸部透视 医师签名： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 肝脏功能 | | |  | | | | | | | | | | | | | | | | | | | 体检结论 | | | 主检医师签名：  年 月 日（医院盖章） | | | | | | | | | | | |
| 主检医师意见：  签名： | | | | | | | | | | | | | | | | | | | | | |

说明：1.“既往病史”一栏，申请人必须如实填写，如发现有隐瞒严重病史，不符合认定条

件者，即使取得资格，一经发现收回认定资格。2.主检医师作体检结论要填写合格、不合格两种结论，并简单说明原因。

浙江省申请幼儿园教师资格人员体格检查表

（2010年12月制订）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 身份证号码 | | | | |  | |  |  |  |  | | |  | | |  | |  |  | | |  | |  | |  | | |  | |  | | |  | |  |  |  | 一寸照片 | |
| 姓 名 | | | | |  | | | | | | | | | | | | | | | | | | | 主检医师意见：  签名： | | | | | | | | | | | | | | |
| 性别 | | |  | | 出生年月 | | | |  | | | | | | | | | | | | | | |
| 既往  病史 | | | 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： | | | | | | | | | | | | | | | | | | | | |
| 眼科 | | 裸眼视力 | | | 右： | | | | | | 矫正视力 | | | | | | 右：矫正度数 | | | | | | | | | | | | | | | 检查者 | | | | | | | 医师意见：  签名： | |
| 左： | | | | | | 左：矫正度数 | | | | | | | | | | | | | | |
| 色觉检查 | | | | 彩色图案及彩色数码检查：  色觉检查图名称：  单色识别能力检查：（色觉异常者查此项）  红（ ） 黄（ ） 绿（ ） 蓝（ ） 紫（ ） | | | | | | | | | | | | | | | | | | | | | | | | | | 检查者 | | | | | | |
| 眼病 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 内科 | | 血压 | | | | / kpa | | | | | | | | | | | | | | | | | | | | | | 检查者 | | | | | | | | | | | 医师意见：  签名： | |
| 发育情况 | | | |  | | | | | | | | | | | | | | 心脏及血管 | | | | | | | |  | | | | | | | | | | |
| 呼吸系统 | | | |  | | | | | | | | | | | | | | 神经系统 | | | | | | | |  | | | | | | | | | | |
| 腹部器官 | | | | 肝 脾 肾 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 其它 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 外科 | | 身高 | | | | 厘米 | | | | | | | | | 体重 | | | | | 千克 | | | | | | | | | | 颈部 | | | | |  | | | | 医师意见：  签名： | |
| 皮肤 | | | |  | | | | | | | | | 面部 | | | | |  | | | | | | | | | | 关节 | | | | |  | | | |
| 脊柱 | | | |  | | | | | | | | | 四肢 | | | | |  | | | | | | | | | | 检查者 | | | | | | | | |
| 其它 | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 耳鼻喉 | | 听力 | | | | 左耳 米 | | | | | | | | 右耳 米 | | | | | | | | | 检查者 | | | | | | |  | | | | | | | | | 医师意见：  签名： | |
| 嗅觉 | | | |  | | | | | | | | | | | | | | | | | 检查者 | | | | | | |  | | | | | | | | |
| 耳鼻咽喉 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 口腔科 | | 唇腭 | | | |  | | | | | | | | | | | | | | | | | | | | | 是否口吃 | | | | | |  | | | | | | 医师意见：  签名： | |
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| 其它 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 胸部透视 医师签名： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 化验检查 | 丙氨酸氨基转移酶(ALT) | | | | | | | | | | |  | | | | | | | | | 滴虫 | | | | | | | | | | | | | | |  | | | | 检查者 |
| 淋球菌 | | | | | | | | | | |  | | | | | | | | | 梅毒螺旋体 | | | | | | | | | | | | | | |  | | | |
| 外阴阴道假丝酵母菌（念珠菌） | | | | | | | | | | |  | | | | | | | | | 其他 | | | | | | | | | | | | | | |  | | | |
| 肝脏功能 | | | |  | | | | | | | | | | | | | | | | | 体检结论 | | | | 主检医师签名：  年 月 日（医院盖章） | | | | | | | | | | | | | | | |
| 主检医师意见：  签名： | | | | | | | | | | | | | | | | | | | | |

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