**附件1：**

**湖北省教师资格申请人员体检表**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓名** | |  | | **年龄** |  | | | **性别** | | |  | | **婚否** | |  | | **民族** | |  | **一寸照片** |
| **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** | **丙氨酸氨基转移酶（ALT）** | | |  | | | | | **其 它** | | | | | | |  | | | | **签名** |
| **心电图检查** | | | |  | | | | | | | | | | | | | | | | **签名** |
| **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”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.本表适用于除幼儿园类别以外其他类别教师资格申请人员；3.体检结论要填写合格或不合格结论，并简要说明原因。**

**附件2：**

**湖北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** | |  | **一寸照片** |
| **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** | | |  | | | | | | | | | | | | | | | |
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| **神经及精神** | | |  | | | | | | | | | | | | | | | |
| **其它** | | |  | | | | | | | | | | | | | | | |
| **化验检查** | **丙氨酸氨基转移酶（ALT）** | | |  | | | | | **外阴阴道假丝酵母菌（念珠菌）** | | | | | | |  | | | | **签名** |
| **淋球菌** | | |  | | | | | **滴 虫** | | | | | | |  | | | |
| **梅毒螺旋体** | | |  | | | | | **其 他** | | | | | | |  | | | |
| **心电图检查** | | | |  | | | | | | | | | | | | | | | | **签名** |
| **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** | | | | | | | | | | | | | | | | | |

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