附件1

贵州省申请认定教师资格体检表（幼儿园）

编号：

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 | |  | 性别 |  | 年龄 |  | 婚否 |  | 民族 |  | 相片 |
| 文化程度 | |  | 职业 |  | | 申请教师  资格类别 | |  | | |
| 单位或住址 | |  | | | | | 电话 |  | | |
| 既往病史 | | 1、肝炎 2、结核 3、皮肤病 4、性传播疾病  5、精神病 6、其他  受检者确认签字： | | | | | | | | |
| 五  官  科 | 眼 | 裸  眼  视  力 | 右 |  | 矫  正  视  力 | 右 |  | 矫  正  度  数 | 右 |  | 医师意见： |
| 左 |  | 左 |  | 左 |  |
| 辨色力 | | |  |  | | | | |
| 耳 | 听  力 | 右米 | | 耳  疾 |  | | | | | 医师意见： |
| 左米 | |
| 鼻 | 嗅  觉 |  | | 鼻  疾 |  | | | | |
| 咽  喉 |  | | | 语  音 |  | | | | |
| 口腔 | 口腔  唇腭 |  | | 齿 |  | | | | | 医师意见： |
| 口吃 |  | |
| 外  科 | 身高 |  |  | 公分 | 胸廓 | |  | | | | 医师意见： |
| 体重 |  |  | 公斤 | 脊柱 | |  | | | |
| 淋巴 |  | | | 甲状腺 | |  | | | |
| 四肢 |  | | | 关节 | |  | | | |
| 面部 |  | | |  | | | | | |
| 内  科 | | 营养状况 | |  | | | | | | | 医师意见： |
| 血压 | | /Kpa | | | | | | |
| 心脏及血管 | |  | | | | | | |
| 腹部器官 | |  | | 肝 | |  | | |
| 脾 | |  | | |
| 神经及精神 | |  | | | | | | |
| 其它 | |  | | | | | | |
| 胸部X  线透视 | |  | | | | | | | | | 医师意见： |
| 化  验  检  查 | | 肝功能（ALT、AST） | | | |  | | | | | |
| 二对半 | | | |  | | | | | |
| 淋球菌 | | | |  | | | | | |
| 梅毒螺旋体 | | | |  | | | | | |
| 滴虫 | | | |  | | | | | |
| 外阴阴道假私酵母菌  （念珠菌） | | | |  | | | | | |
| 体  检  医  院  结  论 | | 负责医师：  年月日（单位盖章） | | | | | | | | | |

贵州省申请教师资格人员体格检查表

附件2

（2010年3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 | | |  | | | | | | | | 有无精神病史 | | | | | | | | |
|  | | | | | | | | |
| 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。.