附件1：

**河北省教师资格申请人员体检表(适用于申请幼儿园教师资格人员)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 姓名 | | | | | | 性别 | | | | | | | 年龄 | | | | | | 婚否 | | | | | 民族 | | | | | | 一寸免冠  近 照 |
| 籍贯 | | | | | | | | | | | | | 联系  电话 | | | | | | | | | | | | | | | | |
| 身份证  号 码 | |  | |  |  | |  | |  |  | |  | |  |  | |  | |  |  | |  |  | |  |  | |  |  |
| 既往病史 | 心脏病 肾炎 肝炎 关节炎 哮喘 精神病 癫痫 肺结核 胃病 性病 皮肤病  （ ）（ ）（ ） （ ） （ ）（ ） （ ）（ ）（ ）（ ）（ ） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 五  官  科 | 裸眼  视力 | | 右 | | | | | 矫正  视力 | | | 右 | | | | | | |  | | | 矫正后  视力 | | | | | | 右 | | | 医师意见  签字 |
| 左 | | | | | 左 | | | | | | |  | | | 左 | | |
| 辨色力 | |  | | | | | | | | | | | | | | | 眼病 | | |  | | | | | | | | |
| 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 | | | | | | | | | | | | 医师意见  签字 |
| 淋巴 | | | | | | | | | | | | | | | | | 脊柱 | | | | | | | | | | | |
| 四肢 | | | | | | | | | | | | | | | | | 关节 | | | | | | | | | | | |
| 皮肤 | | | | | | | | | | | | | | | | | 头颈 | | | | | | | | | | | |
| 其它 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 内  科 | 营养状况 | |  | | 医师意见  签字 |
| 血压 | |  | |
| 心脏 | |  | |
| 呼吸 | |  | |
| 腹部 | |  | |
| 神经 | |  | |
| 其它 | |  | |
| 妇科检查 | |  | | 医师签字 | |
| 胸部透视 | |  | | 医师签字 | |
| 肝功能 | | 转氨酶 | | 医师签字 | |
| 其他 | |
| 体检结论 | | 负责医师签字 | | | |
| 检验医院  意 见 | | 体检医院公章  年　　月　　日 | | | |

注：1、申请人员须到教师资格认定机构指定的医院体检。2、既往病史一栏，由本人如实填写，须在病名下面划横线，并在括号内写明患病时间。3 妇科检查包括：淋球菌、梅毒螺旋体、滴虫、外阴阴道假丝酵母菌（念球菌）检查项目。(对于滴虫和外阴阴道假丝酵母菌（念球菌）两项妇科检查采取阴道口取样，不进行侵入性检查)

**河北省教师资格申请人员体检表(适用于申请中小学教师资格人员)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 籍贯 | | | | | | | | | | | | | 联系  电话 | | | | | | | | | | | | | | | | |
| 身份证  号 码 | |  | |  |  | |  | |  |  | |  | |  |  | |  | |  |  | |  |  | |  |  | |  |  |
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| 五  官  科 | 裸眼  视力 | | 右 | | | | | 矫正  视力 | | | 右 | | | | | | |  | | | 矫正后  视力 | | | | | | 右 | | | 医师意见  签字 |
| 左 | | | | | 左 | | | | | | |  | | | 左 | | |
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| 面部 | | | | | | | | | | | | | | | 咽喉 | | | | | | | | | | | | | |
| 口腔唇腭 | | | | | | | | | | | | | | | | | | | | 齿 | | | | | | | | |
| 其他 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 外  科 | 身高　　　　　　　　　　　　　公分 | | | | | | | | | | | | | | | | | 体重 | | | | | | | | | | | | 医师意见  签字 |
| 淋巴 | | | | | | | | | | | | | | | | | 脊柱 | | | | | | | | | | | |
| 四肢 | | | | | | | | | | | | | | | | | 关节 | | | | | | | | | | | |
| 皮肤 | | | | | | | | | | | | | | | | | 头颈 | | | | | | | | | | | |
| 其它 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- |
| 内  科 | 营养状况 | |  | | 医师意见  签字 |
| 血压 | |  | |
| 心脏 | |  | |
| 呼吸 | |  | |
| 腹部 | |  | |
| 神经 | |  | |
| 其它 | |  | |
| 心电图 | |  | | 医师签字 | |
| 胸部透视 | |  | | 医师签字 | |
| 肝功能 | | 转氨酶 | | 医师签字 | |
| 其他 | |
| 体检结论 | | 负责医师签字 | | | |
| 检验医院  意 见 | | 体检医院公章  年　　月　　日 | | | |

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