

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 血 | 压 | 毫米汞柱 | 脉搏 |  | 医师意见： |  |
|  |  |  |  |
|  |  |  |  |  |  |  |  |

发 育 及

内

神 经

及精神

肺 及

呼吸道

心 脏

及血管

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | 腹部 |  |  |  | 肝 |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| 科 | | 器官 |  |  |  | 脾 |  |  | |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  | 其他 |  |  |  |  |  |  | 签字： |  |
|  |  |  |  |  |  |  |  |  |  |
|  | | |  |  |  |  |  |  | |  |
| 认定幼儿园教 | | | 淋球菌 |  |  |  | 滴虫 |  | |  |
| 师资格人员必 | | |  |  |  |  |  |  |  |  |
|  |  | 外阴阴道假丝酵母菌 | | |  |  |  |
| 填 | |  | 梅毒螺旋体 |  |  | |  |
|  |  |  | （念球菌） | |  |  |  |
|  |  |  |  |  |  |  | |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | 贴肝功能化验单 | |  |  |  |  |  |  |
| 化验检查 | | |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  | 化验员（签章）： | | |  |
|  | | |  |  |  |  |  |  |  |  |
| 胸部爱克斯线 | | |  |  |  |  |  |  |  |  |
| 透 | | 视 |  |  |  |  |  |  |  |  |
|  |  |  | 医师（签章）： | |  |  |  |  |  |  |

其他检查

检查结论

负责医师（签章）： 医院盖章

备 考

附件 4 年 月 日

**湖南省教师资格认定体检表**

（2018 年 3 月修订）

姓 名



工 作 单 位



户 籍所 在 地



申请资格种类



填 表 日 期



湖南省教育厅监制

— 12 —

**说** **明**

一、体检在相应的教师资格认定机构指定的县级以上医院进行，并

必须包括传染病和精神病史等项目。高等学校教师资格认定体检由拟聘

任教学校统一组织在市州以上医院进行。

二、申请认定幼儿园和小学教师资格的，参照《中等师范学校招生

体检标准》的有关规定执行；申请认定初级中学及其以上教师资格的，

参照《高等师范学校招生体检标准》的有关规定执行。、

三、承担体检的医院应当根据上述标准，对被检人员做出合格或不

合格的结论

第 号

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 姓名 | |  |  |  |  |  | 性别 | |  |  |  |  | 婚否 | | |  |  |  | 民族 | | |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 半身 |  |
| 出生年月 | | |  |  |  |  |  | 身份证号 | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 脱帽 |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 最高学历 | | |  |  |  |  |  | 职业 | |  |  |  |  |  |  |  |  | 籍贯 |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 正面 |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 现住所及 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 相片 |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 通讯地址 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 医院骑缝章 |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 既往病史（须明确标明肝炎、结核、 | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 皮肤病、性传播疾病、精神病、其他， | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 受检者签名： | |  |
| 并受检者确认签字） | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 家族病史 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | 视力 | | 右 |  |  |  |  | 矫正视 | | | |  | 右 | |  |  |  | 辩色力 | | |  |  | 医师意见： |  |
|  |  |  |  |  |  |  |  | 力 | | | |  |  |  |  |  |  |  |  |  |
|  |  |  | 左 |  |  |  |  |  | 左 | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 眼 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 砂眼 | | 右 |  |  |  |  | 其他眼 | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  | 疾 | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 五 |  |  | 左 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 耳 | 听力 | | 右 |  | 公尺 | | | 耳疾 | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 左 |  | 公尺 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 官 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 鼻 | 嗅觉 | |  |  |  |  |  | 鼻及鼻 | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  | 窦疾病 | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 科 |  | 咽喉 |  |  |  |  |  |  |  | 唇腭 | | | |  |  |  |  |  |  | 口吃 |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 齿 | 龋齿 |  |  |  |  |  |  | 缺齿 | | | |  |  |  |  |  |  | 齿槽 |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  | 脓漏 |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 其他 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 签字： |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 身高 |  |  |  | cm |  | 胸围 | | |  |  |  |  |  |  |  | cm |  | 皮肤 | |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 医师意见： |  |
|  |  | 体重 |  |  |  | kg |  | 呼吸差 | | |  |  |  |  |  |  |  | cm |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 淋巴 |  |  |  |  |  | 甲状腺 | | |  |  |  |  |  |  |  |  |  | 脊柱 | |  |  |  |  |  |
| 外 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 四肢 |  |  |  |  |  | 关节 | | |  |  |  |  |  |  |  |  |  | 平嗻足 | |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 泌尿生殖器 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 肛门 | |  |  |  |  |  |
| 科 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 疝 |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 其他 | |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 签字： |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |