

**Documentation of Tuberculosis (PPD) Skin Test  
 and Hepatitis B Immunization**

The University of Wisconsin-La Crosse (UW-L) Teacher Education program requires students to provide official documentation of a negative Tuberculosis (TB) skin test reading within 90 days of beginning the student teaching placement. An official record of Hepatitis B immunization is also required.

The UW-L Student Health Center provides full-time students the TB skin test service for ~\$10.00. There are also other fees for winter-term or summer service. Please call (608)785-8558 to make an appointment, as the days and times the TB skin test can be administered and read are limited. The Student Health Center will provide you a confirmation form to turn in to the Office of Field Experience. Most students received the Hepatitis B immunization a number of years ago; however, if you need to begin the series of three shots, they cost full-time students ~\$30 each. (The Student Health Center fee is subject to change.)

We also accept TB test results and Hepatitis B immunization records from a doctor's office, clinics, the County Health Department, and the Wisconsin Immunization Registry ([www.dhfs.wis.gov](http://www.dhfs.wis.gov)). TB test information should include date and location (right or left arm) administered, as well as date and induration reading result. *The name and address of the clinic or doctor's office must be included, and an appropriate professional representative must **sign** the record.\** The doctor or nurse also has the option to complete and sign the form below. Records may be mailed or delivered to our office or faxed to (608)785-8926.

If you need more information, please call the Office of Field Experience at (608)785-8126.

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Student Legal Name \_\_\_\_\_ UW-L Student ID \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Semester/Year Student Teaching \_\_\_\_\_

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**Hepatitis B**

	_____	_____	_____
	First Dose Date	Second Dose Date	Third Dose Date

**TB Skin Test (PPD)**

	_____	_____	_____	_____
	Date Given	Location	Date Read	Read (mm of induration)

\*  
 \_\_\_\_\_  
 Signature of Clinic Doctor/Professional Representative (**REQUIRED**)

\*  
 \_\_\_\_\_  
 Clinic Name/Address (**REQUIRED**)