Paediatrician Health Certificate

(To be filled in by the Medical Practitioner)

NAME OF CHILD (IN FULL): _____

AGE/DATE OF BIRTH: _____

VACCINATION DONE: _____

DESCRIPTION OF ANY KNOWN OR VISIBLE PAST TREATMENT/CONGENITAL DEFECT(S):

_____

_____

_____

CLINICAL EXAMINATION AND FINDINGS:

CVS: _____

_____

RS: _____

_____

CNS: _____

_____

COMMENTS/OVERALL CHILD CONDITION:

_____

_____

_____

_____

DATE:

DOCTOR'S NAME: _____

SIGNATURE: _____

Once completed, please send this form to:

Medscheme (Mtius) Limited, 1st Floor, Tower A, 1Cybercity, Ebene.
Customer Hotline: 403 5073 Fax: 403 5088 Email: mosante@businessmauritius.org

Kindly write NEW MOSANTÉ MEMBERSHIP FORM on the top RHS of the envelope.