SOCIAL SECURITY

Milk Grant

Doctor's Report

Details of Child *(To be filled by Medical Doctor)*

Name: _____ Surname: _____

Child's Weight: _____ Date Weighed: _ _ / _ _ / _ _ _ _

Is the child being breastfed? ☐ Yes ☐ No

If **Yes**, was it necessary to give the child complementary feeding? ☐ Yes ☐ No

If **No**, tick (✓) as applicable:

(a) It was necessary for child to be weaned; or ☐

(b) Child could not be breastfed due to health reasons ☐

_____
Name of Doctor

_____
Medical Council Number

_____
Signature

Rubber Stamp

_____
Date