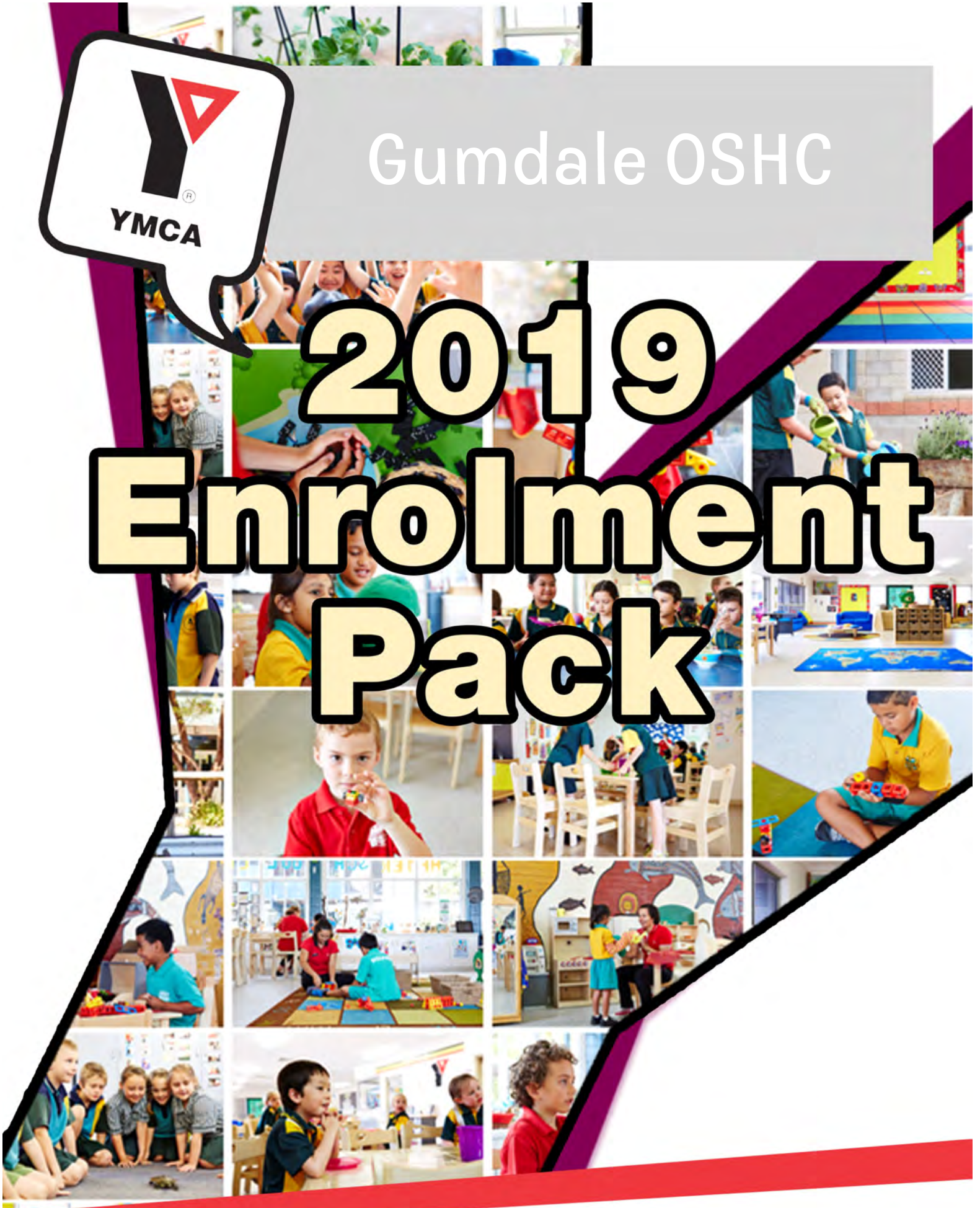
YMCA

Gumdale OSHC

2019 Enrolment Pack



Contact us on:

P: 3890 2675 E: agd@ymcabrisbane.org

YMCA Outside School HOURS CARE

Important information

- Ezidebits are processed on a THURSDAY only and all permanent bookings will be processed on a fortnightly cycle. The first date for 2019 is 3rd January , then 17th January and so on.
- The account holder at the service must be the CRN holder for the account.
- CRNs and date of birth for account holder and children are required to link your account with CCS. Without these you will be required to pay **full fees**, or delay enrolment start date.
- All new enrolments must be confirmed by the CRN Holder through their myGov account.
- Please ensure that all sections on this form are filled out correctly and in full. Incomplete forms will not be accepted by your service Coordinator
- Parents are to advise any changes of bookings in writing, verbal changes will not be accepted.
- If you have any questions, queries or concerns relating to the enrolment of your child, please speak with your friendly Service Coordinator

AUSTRALIAN CHILDHOOD FOUNDATION
SAFEGUARDING CHILDREN
ACCREDITED ORGANISATION

Thank you

Outside School Hours Care Enrolment Form 2019

How did you hear about YMCA OSHC?
☐ Internet ☐ Yellow Pages ☐ Word of Mouth ☐ School ☐ Previous Client ☐ Other_____

ACCOUNT INFORMATION	
Account Holder Name:	**Account Holder CRN:** _ _ _ _ _ _ _ _ _ _
OSHC Location:	
Email Address for Statements:	

PARENT/GUARDIAN 1 (ACCOUNT CRN HOLDER) INFORMATION – PLEASE PROVIDE COPIES OF ID
Guardians are authorised to give permission for an Educator to take a child outside the education and care services premises as per YMCA policy.
Please ensure that Account Holder CRN (above) and Date of Birth (below) is correct to ensure prompt and accurate matching with Centrelink

Name:	DOB:	☐ M ☐ F
Address (H):		Postcode:
Primary Language:	Cultural Background:	Relationship To Child/ren:
Mobile:	Phone (H):	Email:
Phone (W):	Occupation:	Employer:
Address (W):		Postcode:

Office use: Photo ID Sighted ☐ Copy Received ☐

PARENT/GUARDIAN 2 INFORMATION – PLEASE PROVIDE COPIES OF ID
Guardians are authorised to give permission for an Educator to take a child outside the education and care services premises as per YMCA policy

Authority to collect child ☐ Y ☐ N

Name:	DOB:	☐ M ☐ F
Address (H):		Postcode:
Primary Language:	Cultural Background:	Relationship To Child/ren:
Mobile:	Phone (H):	Email:
Phone (W):	Occupation:	Employer:
Address (W):		Postcode:

Office use: Photo ID Sighted ☐ Copy Received ☐

MEDICAL INFORMATION

Family Doctor Name:	
Surgery Name:	
Address:	Phone:

SAFEGUARDING CHILDREN & YOUNG PEOPLE *The YMCA is committed to Safeguarding children and young people and has a range of policies and procedures to keep children and young people safe. Details of these policies are available at: www.ymcabrisbane.org along with information on YMCA's obligation to report child safety concerns, and how you can report child safety concerns.*

Office Use Only

Date received:	*Date Registration Fee paid:*
Date entered into QK:	*Enrolment data entered into QK by:*
Foster/Kinship Care: Was CSO Contacted? ☐ Yes ☐ No	*Foster/Kinship Care:* Were there any risks Identified we need to manage? Yes ☐ No ☐
If Yes has RMP been Developed? Yes ☐ No ☐	*If not, why not:*

AUTHORISED NOMINEES/EMERGENCY CONTACTS – Please provide copies of ID

Authorised Nominees/Emergency contacts are people over the age of 18. *Emergency contacts are unable to authorise an educator to take a child outside the education and care service premises without written permission from the parent/guardian.*
By listing contacts below, you are providing authorisation for YMCA OSHC to contact contacts in the event of an Emergency.
Please place in specific call order, you must supply a minimum of 1;

AUTHORISED NOMINEE/EMERGENCY CONTACT 3 *Photo ID ☐ Sighted ☐ Copy Received*

Name:	This person is authorised to provide the following authorisations for my child/ren: *(please tick appropriate boxes)*
Relationship:	☐ Drop off or Collect child/ren to/from the service and authorised to use QikKids Kiosk
Address:	☐ Medical treatment/Medical administration
Phone:	
Work Phone:	
Mobile:	

AUTHORISED NOMINEE/EMERGENCY CONTACT 4 *Photo ID ☐ Sighted ☐ Copy Received*

Name:	This person is authorised to provide the following authorisations for my child/ren: *(please tick appropriate boxes)*
Relationship:	☐ Drop off or Collect child/ren to/from the service and authorised to use QikKids Kiosk
Address:	☐ Medical treatment/Medical administration
Phone:	
Work Phone:	
Mobile:	

AUTHORISED NOMINEE/EMERGENCY CONTACT 5 *Photo ID ☐ Sighted ☐ Copy Received*

Name:	This person is authorised to provide the following authorisations for my child/ren: *(please tick appropriate boxes)*
Relationship:	☐ Drop off or Collect child/ren to/from the service and authorised to use QikKids Kiosk
Address:	☐ Medical treatment/Medical administration
Phone:	
Work Phone:	
Mobile:	

AUTHORISED NOMINEE/EMERGENCY CONTACT 6 *Photo ID ☐ Sighted ☐ Copy Received*

Name:	This person is authorised to provide the following authorisations for my child/ren: *(please tick appropriate boxes)*
Relationship:	☐ Drop off or Collect child/ren to/from the service and authorised to use QikKids Kiosk
Address:	☐ Medical treatment/Medical administration
Phone:	
Work Phone:	
Mobile:	

If any of the above Authorised Persons have not collected my child at the service closing time, I give permission for the Responsible Person in Charge to make necessary provisions to secure the care of my child. I also agree to pay a late pick up fee if I collect my child past licensed closing time of the service:

Signature: _____ Date: _____

CHILD 1 DETAILS *Please ensure that child CRN and Date of Birth is correct to ensure prompt and accurate matching with Centrelink* *Health Record* ☐ *Sighted* ☐ *Copy Received*

Name: Preferred Name:

Child CRN: _ _ _ _ _ _ _ _ _ _ DOB: ☐ M ☐ F

Cultural background:

Child's Address: Postcode:

Year Level in 2019: Language Spoken at home:

Child's Medicare Number: Reference Number: Expiry Date:

Initial Booking Pattern: ☐ **Casual** ☐ **Permanent** ☐ Weekly Pattern ☐ Fortnightly Pattern **Care Start Date:**

Booking Type:

☐ **Complying Written Arrangement** - Registered with Centrelink, wanting to claim CCS now. Care Agreement needs to be confirmed by parent in myGov account. FULL FEES WILL APPLY UNTIL CCS IS GRANTED BY CENTRELINK AND PARENT CONFIRMS BOOKING THROUGH MY GOV ACCOUNT.

☐ **Relevant Arrangement** - Does not wish to claim CCS now or at a later date. No confirmation needed in myGov. FULL FEES WILL APPLY FOR ENTIRE PERIOD OF ENROLMENT

☐ **Arrangement with Organisation** - Fees being paid by third party (i.e. Austim Qld, Charity group, Employer) and the external party will be responsible for FULL FEES to be paid with no CCS able to be applied.

Week 1 Before School:	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
Week 1 After School:	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
If Fortnightly Pattern please complete Week 2 **Week 2 Before School:**	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
Week 2 After School:	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**

Is child of Aboriginal (A) or Torres Strait Islander (T) Origin? ☐ No ☐ Yes (A) ☐ Yes (T)

Disabilities, allergies, anaphylaxis or medical conditions and details:

Management Plan supplied: ☐ Yes ☐ No
Please see Coordinator for forms 07-616, 07-534 ,07-669

Details of Parental Custody/Court Orders: Documentation attached: ☐ Yes ☐ No

Is there anyone legally denied access to child? ☐ Yes ☐ No
Name:

Is the child in foster/kinship care? ☐ Yes ☐ No
Do you have a Risk Management Plan for the child? ☐ Yes ☐ No

If yes, please be advised we will contact the Child Safety Officer to confirm if there are any matters we need to be aware of that may impact the care arrangement, and if necessary we will work with you and Child Safety to develop a Risk Management Plan.

Please provide contact details of the Child Safety Officer:

Has child received the relevant immunisations for their age?* ☐ No ☐ Yes
**If YES please provide copy of child's Health Record to Coordinator*

Does child have any additional needs?* ☐ No ☐ Yes
**If YES please see Coordinator to complete forms 07-616 and 07-669*

Does child require staff to administer medication?* ☐ No ☐ Yes
**If YES please see Coordinator to complete form 07-534*

Has child had a history of ill health or been hospitalised? ☐ No ☐ Yes

Does your child have any fears? ☐ No ☐ Yes
**If YES please provide details:*

Are there any behavioural issues that you would like the service staff to be made aware of? ☐ No ☐ Yes

Are there any particular food or drink preferences for your child?* ☐ No ☐ Yes
**If YES please see Coordinator to complete form 07-612*

Does your family participate in any particular religious or cultural practises that are significant for your child? ☐ No ☐ Yes
**If YES please provide details:*

CHILD 2 DETAILS *Please ensure that child CRN and Date of Birth is correct to ensure prompt and accurate matching with Centrelink* *Health Record* ☐ *Sighted* ☐ *Copy Received*

Name: Preferred Name:

Child CRN: _ _ _ _ _ _ _ _ _ _ DOB: ☐ M ☐ F

Cultural background:

Child's Address: Postcode:

Year Level in 2019: Language Spoken at home:

Child's Medicare Number: Reference Number: Expiry Date:

Initial Booking Pattern: ☐ **Casual** ☐ **Permanent** ☐ Weekly Pattern ☐ Fortnightly Pattern **Care Start Date:**

Booking Type:

☐ **Complying Written Arrangement** - Registered with Centrelink, wanting to claim CCS now. Care Agreement needs to be confirmed by parent in myGov account. FULL FEES WILL APPLY UNTIL CCS IS GRANTED BY CENTRELINK AND PARENT CONFIRMS BOOKING THROUGH MY GOV ACCOUNT.

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☐ **Arrangement with Organisation** - Fees being paid by third party (i.e. Austim Qld, Charity group, Employer) and the external party will be responsible for FULL FEES to be paid with no CCS able to be applied.

Week 1 Before School:	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
Week 1 After School:	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
If Fortnightly Pattern please complete Week 2 **Week 2 Before School:**	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
Week 2 After School:	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**

Is child of Aboriginal (A) or Torres Strait Islander (T) Origin? ☐ No ☐ Yes (A) ☐ Yes (T)

Disabilities, allergies, anaphylaxis or medical conditions and details:

Management Plan supplied: ☐ Yes ☐ No
Please see Coordinator for forms 07-616, 07-534 ,07-669

Details of Parental Custody/Court Orders: Documentation attached: ☐ Yes ☐ No

Is there anyone legally denied access to child? ☐ Yes ☐ No
Name:

Is the child in foster/kinship care? ☐ Yes ☐ No
Do you have a Risk Management Plan for the child? ☐ Yes ☐ No

If yes, please be advised we will contact the Child Safety Officer to confirm if there are any matters we need to be aware of that may impact the care arrangement, and if necessary we will work with you and Child Safety to develop a Risk Management Plan.

Please provide contact details of the Child Safety Officer:

Has child received the relevant immunisations for their age?* ☐ No ☐ Yes
**If YES please provide copy of child's Health Record to Coordinator*

Does child have any additional needs?* ☐ No ☐ Yes
**If YES please see Coordinator to complete forms 07-616 and 07-669*

Does child require staff to administer medication?* ☐ No ☐ Yes
**If YES please see Coordinator to complete form 07-534*

Has child had a history of ill health or been hospitalised? ☐ No ☐ Yes

Does your child have any fears? ☐ No ☐ Yes
**If YES please provide details:*

Are there any behavioural issues that you would like the service staff to be made aware of? ☐ No ☐ Yes

Are there any particular food or drink preferences for your child?* ☐ No ☐ Yes
**If YES please see Coordinator to complete form 07-612*

Does your family participate in any particular religious or cultural practises that are significant for your child? ☐ No ☐ Yes
**If YES please provide details:*

CHILD 3 DETAILS *Please ensure that child CRN and Date of Birth is correct to ensure prompt and accurate matching with Centrelink* *Health Record* ☐ *Sighted* ☐ *Copy Received*

Name: Preferred Name:

Child CRN: _ _ _ _ _ _ _ _ _ _ DOB: ☐ M ☐ F

Cultural background:

Child's Address: Postcode:

Year Level in 2019: Language Spoken at home:

Child's Medicare Number: Reference Number: Expiry Date:

Initial Booking Pattern: ☐ **Casual** ☐ **Permanent** ☐ Weekly Pattern ☐ Fortnightly Pattern **Care Start Date:**

Booking Type:

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Week 1 Before School:	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
Week 1 After School:	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
If Fortnightly Pattern please complete Week 2 **Week 2 Before School:**	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**
Week 2 After School:	☐ **Monday**	☐ **Tuesday**	☐ **Wednesday**	☐ **Thursday**	☐ **Friday**

Is child of Aboriginal (A) or Torres Strait Islander (T) Origin? ☐ No ☐ Yes (A) ☐ Yes (T)

Disabilities, allergies, anaphylaxis or medical conditions and details:

Management Plan supplied: ☐ Yes ☐ No
Please see Coordinator for forms 07-616, 07-534 ,07-669

Details of Parental Custody/Court Orders: Documentation attached: ☐ Yes ☐ No

Is there anyone legally denied access to child? ☐ Yes ☐ No
Name:

Is the child in foster/kinship care? ☐ Yes ☐ No
Do you have a Risk Management Plan for the child? ☐ Yes ☐ No

If yes, please be advised we will contact the Child Safety Officer to confirm if there are any matters we need to be aware of that may impact the care arrangement, and if necessary we will work with you and Child Safety to develop a Risk Management Plan.

Please provide contact details of the Child Safety Officer:

Has child received the relevant immunisations for their age?* ☐ No ☐ Yes
**If YES please provide copy of child's Health Record to Coordinator*

Does child have any additional needs?* ☐ No ☐ Yes
**If YES please see Coordinator to complete forms 07-616 and 07-669*

Does child require staff to administer medication?* ☐ No ☐ Yes
**If YES please see Coordinator to complete form 07-534*

Has child had a history of ill health or been hospitalised? ☐ No ☐ Yes

Does your child have any fears? ☐ No ☐ Yes
**If YES please provide details:*

Are there any behavioural issues that you would like the service staff to be made aware of? ☐ No ☐ Yes

Are there any particular food or drink preferences for your child?* ☐ No ☐ Yes
**If YES please see Coordinator to complete form 07-612*

Does your family participate in any particular religious or cultural practises that are significant for your child? ☐ No ☐ Yes
**If YES please provide details:*

ENROLMENT AGREEMENT

- I/We agree that fees must remain paid as per the YMCA OSHC Fee Policy. I/We agree that it is my/our responsibility to ensure all Centrelink requirements are fulfilled and that I/We must provide relevant Date of Birth and CRN's to link with Centrelink. I/We agree that failing to provide relevant information or fail to communicate with Centrelink regarding my/our circumstances I/we will be required to pay full fees. I/We understand that fee's may change during the time of my enrolment and I will be notified of these by YMCA OSHC Educators.
- I/We agree to pay any relevant additional charges including, but not limited to, Late Fees, Cessation of Care and Incursion and Excursion fees.

Parent/Guardian Name:

Signature: **Date:**

Parent/Guardian Name:

Signature: **Date:**

- I/We agree to notify the Coordinator of any change to information provided on the enrolment form. ☐ No ☐ Yes
- I/We acknowledge that it is my/our responsibility to read the Parent Handbook which is on the website www.ymcachildcare.com.au and agree to abide by the rules, policies and procedures of the service. ☐ No ☐ Yes
- I/We have read the Access for Families Policy and understand that if necessary I/we may lose my/our bookings. ☐ No ☐ Yes
- I/We understand that it is necessary to personally sign child/ren out as required for the various care sessions. If any person apart from those listed on the enrolment form is to collect and sign out my/our child/ren, I/we agree to notify the Coordinator in advance and in writing to this effect. ☐ No ☐ Yes
- I/We understand that management and/or staff **cannot** enforce Family Court Orders or Domestic Violence Orders by law. ☐ No ☐ Yes
- I/We understand that, in the case of a Foster Care arrangement, management can contact the Case Worker to obtain strategies to work with the child/ren. ☐ No ☐ Yes
- I/We agree to keep my/our child/ren from attending the Program should he/she be suffering from any infectious or contagious disease as recognised by the National Health and Medical Research Council (NHMRC). I/We accept that the Coordinator will enforce the NHMRC "Recommended Minimum Exclusion Periods from School, of Infectious Disease Cases". ☐ No ☐ Yes
- I/We understand that if do not provide a current Health Record my child will be considered as "Not-up-to-date" or not Immunised until such time as I/We provide the Health Record. ☐ No ☐ Yes
- I/We authorise all YMCA staff to provide any required first aid and further to ensure that appropriate medical attention is provided in an emergency. I/We give permission for YMCA to obtain at my/our cost medical, hospital and ambulance service in the case of an accident or emergency involving my/our child/ren. ☐ No ☐ Yes
- I/We give permission for staff and students to observe my/our child/ren to assist in developing activity programs. ☐ No ☐ Yes
- I/We give permission for staff to apply sunscreen to my/our child/ren prior to outdoor play. ☐ No ☐ Yes
- I/We give permission for my/our child/ren's name and/or photograph to be used for promotional purposes and service displays. ☐ No ☐ Yes
- I/We give permission for YMCA OSHC to use the email address provided to contact me/us regarding account issues and keep me/us updated with service newsletters and information. ☐ No ☐ Yes
- I/We give permission for OSHC staff to liaise with my/our child/ren's school administration staff to obtain contact details in an emergency. ☐ No ☐ Yes
- I/We give permission for OSHC staff to liaise with my/our child/ren's teacher when relevant to the well-being of my child/ren. ☐ No ☐ Yes
- I/We understand that copies of all of the parents, guardians and emergency contacts ID need to be attached in order to allow YMCA staff to relinquish care of my child/ren to any of the named ☐ No ☐ Yes

Parent/Guardian Name:

Signature: **Date:**

Parent/Guardian Name:

Signature: **Date:**

YMCA OF BRISBANE OUTSIDE SCHOOL HOURS CARE

Authorisation to Administer Medication

07 - 534

AUTHORISATION

CHILD'S NAME:

PARENT/GUARDIAN NAME:

- As the parent/guardian of the above mentioned child I request and authorise YMCA OSHC to administer the following medication.
- I warrant that the medication provided to YMCA OSHC with this authority is that as described below.
- I am aware that any information regarding changes to this medication including type, dosage etc must be forwarded to YMCA OSHC in writing.
- I am aware that it is my responsibility to maintain an adequate supply of this medication at YMCA OSHC.

PARENT SIGNATURE: DATE:

ADMINISTRATION INFORMATION

NAME OF MEDICATION:

QUANTITY ON HAND OVER (TABLETS/ML):

PERIOD FOR WHICH MEDICATION IS TO BE ADMINISTERED: From: To:

FREQUENCY OF DOSAGE: (IE, SPECIFIC TIMES)

TIME & DATE OR CIRCUMSTANCE, THE MEDICATION IS TO BE GIVEN WHILE IN CARE:

MEDICATION DOSAGE:

DOCTORS NAME:

TELEPHONE: DOCTORS LETTER ATTACHED: ☐ Yes ☐ No

HAS THE CHILD TAKEN THIS MEDICATION PREVIOUSLY? ☐ Yes ☐ No

IF NO, STAFF ARE UNABLE TO GIVE ANY MEDICATION THAT HAS NOT BEEN PREVIOUSLY ADMINISTERED.

IF YES, WAS THERE ANY ADVERSE REACTION? ☐ Yes ☐ No

TIME & DATE OF MEDICATION LAST ADMINISTERED?

MANNER IN WHICH MEDICATION WAS ADMINISTERED?
(EG. ORALLY, NASALLY?)

OTHER INSTRUCTIONS:

SERVICE USE ONLY	
The medication supplied with this authorisation is: ☐ A prescribed medication; and ☐ In its original package with a pharmacist's label which clearly states the child's name, dosage, frequency of administration, date of dispensing and expiry date.	
COORDINATOR SIGNATURE:	DATE:

YMCA BRISBANE OUTSIDE SCHOOL HOURS CARE

Food Considerations Form 07 - 612

SERVICE:

CHILD'S NAME:

FOOD CONSIDERATION:

MUST NOT EAT	ALTERNATIVES

FURTHER INFORMATION

SIGNATURE: DATE:

STANDARD IMAGE RELEASE FORM

PERMISSION TO USE PHOTOGRAPHS, VIDEO, AUDIO, IMAGES AND/OR ARTWORK

May we use your, or your children/s, photo/s, audio, video, images and/or artwork in our YMCA social media sites, newsletters, website, or any other promotional material including, but not limited to, posters, flyers or banners?

☐ **Yes, I give permission**

☐ **No, I do not give permission**

I understand that I can withdraw my consent at any time but I must do so in writing and forward it to the YMCA of Brisbane.

COPYRIGHT RELEASE

I, _____ , agree to and provide permission for the photographic, video, written and audio or any other form of electronic recording of me and/or my child/ren (whose names are listed below) to be used for and on behalf of the YMCA. I acknowledge that ownership of any photographic, video, audio or any other form of electronic recording or artwork will be retained by the YMCA.

I authorise the use or reproduction of any recording referred to above for the purposes of publishing information materials and resources which promote the initiatives of the YMCA without acknowledgment and without being entitled to remuneration or compensation. Any photos, videos, artwork or audio may be used on website or social media pages available to the wider community.

I understand the nature and the consequences of what is being proposed above. If there has been any matter of uncertainty, I confirm that I have sought clarification from a staff member of the YMCA who has explained any such uncertainty to my satisfaction.

CHILD DETAILS (If applicable)

Child name/s:

1.	**3.**
2.	**4.**

MY DETAILS

NAME: _____

SIGNATURE: _____

DATE: _____

CONTACT NUMBER: _____

The term 'YMCA' refers to YMCA of Brisbane and Y-Care (South East Queensland) Inc.

YMCA Brisbane
107 Brunswick St, Fortitude Valley, QLD, 4006
PO Box 669, Spring Hill, QLD, 4004
T. (07) 3253 1700 **F.** (07) 3253 1711
E. brisbane@ymcabrisbane.org
W. www.ymcabrisbane.org

OFFICE USE ONLY	
YMCA Location:	
Photo, image, video details	

All about Me

My name is:

Just the Facts

I am ____ years old and am in Grade ____.

The members of my family are: _____

_____

Some of my friends that go to OSHC are: _____

_____

My birthday is: _____

Some of my Favourite things

Food: _____

Sandwich: _____

Fruit: _____

Outdoor activity: _____

Indoor activity: _____

Awesome Activity

One thing I like to do that doesn't involve video games or TV is:

Picture Perfect

This is a drawing or photo of me:

Best Book

My favourite book of all time is:

My Hero

One person who inspires me is:

Did you Know?

Something you might not know about me:

MY mini Autobiography

Some more information about me:

All about Me

My name is:

Just the Facts

I am ____ years old and am in Grade ____.

The members of my family are: _____

_____

Some of my friends that go to OSHC are: _____

_____

My birthday is: _____

Some of my Favourite things

Food: _____

Sandwich: _____

Fruit: _____

Outdoor activity: _____

Indoor activity: _____

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Did you Know?

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MY mini Autobiography

Some more information about me:

GUMDALE YMCA
A: 677 Cleveland Road, Gumdale, QLD, 4154
ABN: 61028995366

APCA ID 184534 | AFSL 338256

Direct Debit Request - Authorisation Form

Customer Details

First Name: Surname:

Phone: Mobile:

Date of Birth: / /

Address:

Suburb: State: Postcode:

Email Address

Select from the Following

☐ New Account ☐ Change Debit Limit ☐ Change Account Details

Payment Details

Payment Limit Amount: *This is the maximum amount to deduct at each centre where a balance*

$0.00 or Blank = No Limit

Surcharge: Visa/MasterCard: 1.40% AMEX: 4.07% Bank Account: N/A Admin Fee: N/A

Payment frequency: ☐ Weekly *(default)* ☐ Fortnightly N/A 4-Weekly **Day of th** THURSDAY

N/A Monthly **Day of the month:** N/A

First Payment Date: / / / Please see Coordinator for payment dates

Direct Debit from Bank Account, Building Society Or Credit Union

Details of the Account to be debited (All Details must be supplied):

Account Name:

BSB Number:

Account Number

DIRECT DEBIT

I/We authorise Debitsuccess Pty Ltd, ABN 095 551 581, APCA User ID Number 184534 to debit my/our account at the Financial Institution identified here through the Bulk Electronic Clearing System (BECS).

Credit Card

Please charge my payments to my: ☐ Visa ☐ Mas ard AMEX

Card number: / / - -

Expiry Date: / Name on Card:

Signature

This Authorisation is to remain in force in accordance with the Terms and Conditions on this Direct Debit Request, the provided DDR Service Agreement, and I/we have read and understood the same.

Authorising Signature (s) Date

/ /

ABN 32 095 551 581
APCA ID 184534 | AFSL 338256

Terms and Conditions

DEBITSUCCESS DIRECT DEBIT REQUEST (DDR) SERVICE AGREEMENT

This Agreement is designed to explain what your obligations are when undertaking a Direct Debit arrangement involving Debitsuccess. It also details what our obligations are to you and forms part of the terms and conditions of your Direct Debit Request (DDR) and should be read in conjunction with your DDR Authorisation Form.

INITIAL TERMS

I/We authorise Debitsuccess Pty Limited (ACN: 095 551 581) APCA User ID 184532 to make periodic debits on behalf of the "Business" as indicated on DDR Authorisation Form (herein referred to as the Business).

I/We acknowledge that if specified by the Business, in addition to the agreed periodic debits set out in the DDR Authorisation Form, administration/setup, variation, reversal, dishonour, or processing fees may also apply and be debited under the DDR as instructed by the Business.

RELATIONSHIP

I/We acknowledge that Debitsuccess is acting as an agent of the Business and that Debitsuccess does not provide any goods or services, and has no express or implied liability in relation to the goods and services provided by the Business or the terms and conditions of any agreement with the Business.

CLEARED FUNDS

I/We acknowledge that is my/our responsibility to ensure that there are sufficient cleared funds in the nominated account by, and at all times on, the due date of the payment ("Day to Debit") to enable the direct debit to be honoured on the Day to Debit. I/We acknowledge and agree that sufficient funds will remain in the nominated account until the direct debit amount has been debited from the account and that if there are insufficient funds available when the debit is attempted, I/we agree that I/we will be responsible for any fees and charges that may be charged by my/our Financial Institution.

VARIATIONS TO DEBIT TERMS

I/We authorise the Business to vary the amount of the payments from time to time if provided for within my/our agreement with the Business. I/We authorise Debitsuccess to vary the amount of the payments upon instructions from the Business, and where such instructions from the Business are received by Debitsuccess, I/we do not require Debitsuccess to notify me/us of such variations to the debit amount.

I/We acknowledge that Debitsuccess/Business is to provide 14 days' notice if proposing to vary the terms of the debit arrangements otherwise than as provided for herein.

I/We acknowledge that my/our requests to vary, defer or stop the debit arrangement must be directed to the Business.

CANCELLING THESE DEBIT TERMS

I/We understand that I/we are able to cancel this DDR by requesting this of the Business or my/our Financial Institution, and I/we acknowledge that cancellation of the authority to debit my/our account will not terminate my/our agreement with the Business or remove my/our liability to make the payments I/we have agreed to.

NON WORKING DAY

When the day to debit falls on a weekend or public holiday the debit will be initiated on the next working day.

DISHONOURED PAYMENTS

I/We acknowledge that:

(a) if a debit is returned by my/our Financial Institution as unpaid, I/we will be responsible for any Debitsuccess fees and charges (currently up to $14.95 for each unsuccessful debit), in addition to any Financial Institution charges and collection fees (including, but not limited to, any fees of solicitors and collection agents appointed by Debitsuccess); and

(b) Debitsuccess may attempt to re-process any unsuccessful payments as advised by the Business and/or add such unsuccessful payment to any future payments.

ACCURACY OF INFORMATION

I/We acknowledge that it is my/our responsibility to ensure that the details entered on the DDR Authorisation Form are correct and that Debitsuccess is not liable to the extent that any such details are wrong and this causes a required payment to be missed. In addition, where I/we are paying the required payments by credit card and have entered the details of the credit card on the DDR Authorisation Form, I/we agree that Debitsuccess may continue to debit from the credit card in accordance with the terms of this Agreement to the extent that the credit card has expired, and that it wholly my/our responsibility to provide details of any replacement credit card to Debitsuccess via the Business.

DISPUTES

I/We acknowledge that any disputes regarding debit payments will be directed to the Business. If no resolution is forthcoming, I/we understand that I/we are to direct any such dispute to my/our Financial Institution.

OTHER AUTHORISATIONS

I/We authorise:

(a) The Debitsuccess to verify details of my/our account with my/our Financial Institution; and

(b) The Financial Institution to release information allowing Debitsuccess to verify my/our account details.

INFORMATION SECURITY

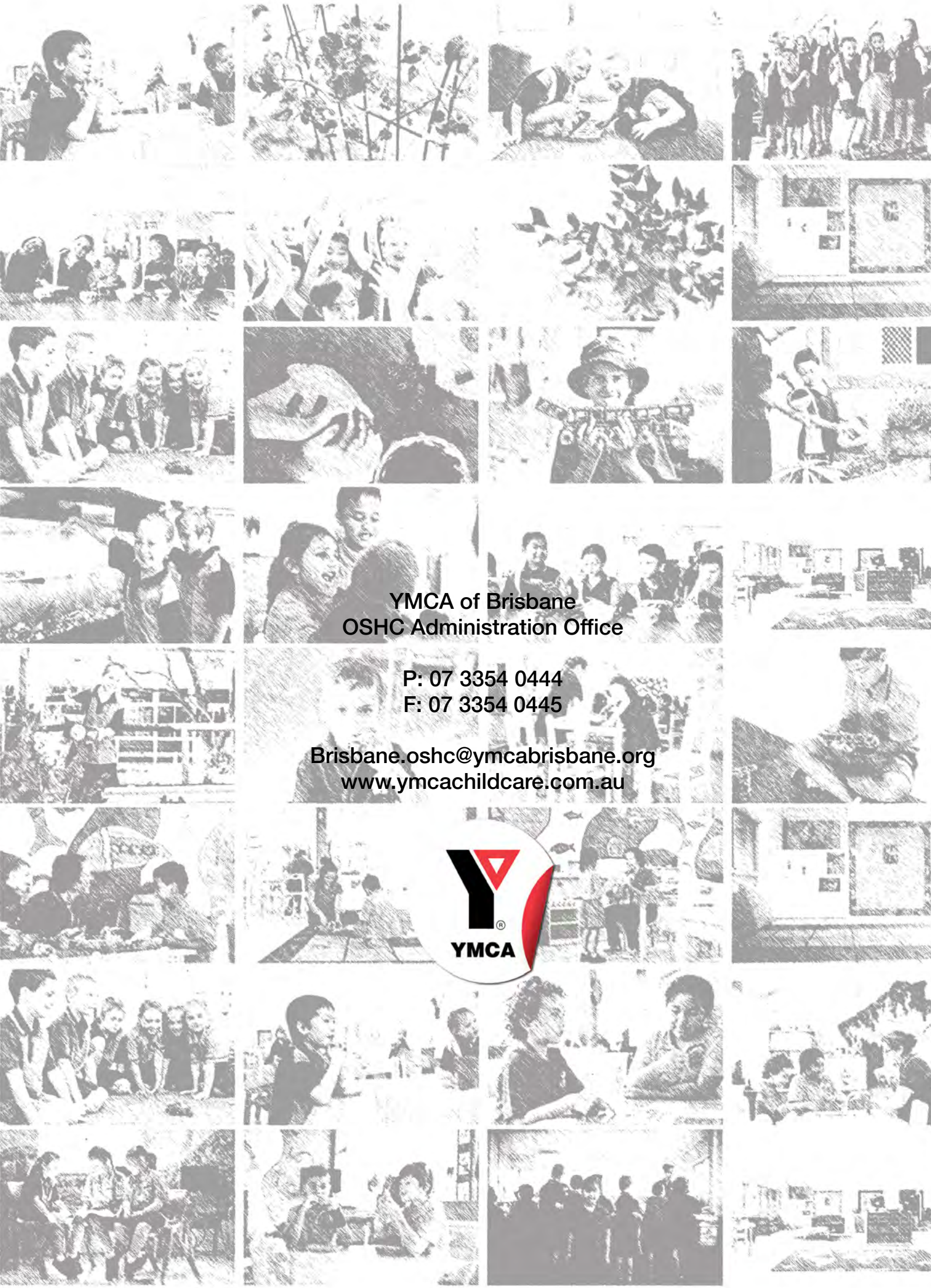
Debitsuccess agrees that it will make reasonable efforts to keep your information contained in the DDR (including account details) and any other information that we have about you confidential and secure, and will ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.

Debitsuccess will only disclose information that we have about you:

(a) to the extent specifically required by law; or

(b) for the purposes of this Agreement (including disclosing information in connection with any query or claim).

Should you have any queries in relation to these terms and conditions contact
Debitsuccess Pty Ltd.
PO BOX 5567, Stafford Heights QLD 4053
Phone: 1800 956 959
E-mail: qkclients@debitsuccess.com



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