



**PCYC QUEENSLAND:
SCHOOL AGE CARE ENROLMENT FORM**

Please complete this form if you wish to enrol your child (ren) into our School Age Care program. Please ensure all information is correct and where appropriate, corresponds exactly with information held by Centrelink. Missing information and/or unrecognised information will result in you receiving no fee assistance through the Government's Child Care Benefit scheme. Please question any point you are unclear about with the service's coordinator.

Key Enrolment Information - Child 1

First Name:

Middle Name:

Last Name:

Child CRN:

(Example 322 323 611A (CRN - Customer Reference Number) - (You will be charged FULL FEE (No Government CCB assistance) if NO or UNRECOGNISED child CRN is provided.)
 Child's D.O.B / / dd/mm/yy Priority of Access

(You will be charged FULL FEE (No Government CCB assistance) if NO or UNRECOGNISED child D.O.B is provided. Please refer to your paper work from Centrelink for your priority of access number, alternatively contact Centrelink.

PCYC Membership # To be enrolled all children must be PCYC members

Gender: Female Male

Indigenous Status NOT Aboriginal OR Torres Strait Islander
 [indicate which Aboriginal AND Torres Strait Islander
 best describes Aboriginal NOT Torres Strait Islander
 your child] Torres Strait Islander NOT Aboriginal

Religious/Cultural Requirements Does your child have any religious/cultural requirements?

If your child does have a cultural/religious requirement please provide passport size photo of your child

Photos -yes I authorize my child's photograph to be taken and used at the service, understanding I will be informed if it will be used for media purposes.

Swimming Ability Can't Swim Good Swimmer
 Poor Swimmer Excellent Swimmer

Dietary Requirements Does your child have any special dietary requirements? Provide information below

If your child does have special dietary requirements please provide a passport size photo of your child.

Supplementary Enrolment Information

School Start Date / / (Approximate Date is sufficient)

School Attends:

City/Town of Birth:

Nationality:

Language spoken at home

Parenting Orders

Parenting Orders, previously know as Court Orders (Prior to Family Law Ac 1996) can include Parenting Plans, Parental Responsibility, Plans, Residence Orders and Contact Orders.

If you are separated / divorced, who has legal custody of your child?

Parent 1 :Name

Parent 2 :Name

Both

Are there any court orders relating to the powers and responsibilities of the parents in relation to the child or access to the child?

Yes (complete below) No

Parent 1 Access Arrangements

Full Time Arrangement Details:

Limited

Parent 2 Access Arrangements

Full Time Arrangement Details:

Limited

Health Details

Immunisation Status

Please mark this box if your child's immunisation status is up to date
 If your child's immunisation status is not up to date your eligibility to receive Government fee assistance through CCB may be affected

Allergies - If necessary continue on separate paper & provide a written treatment plan if one is available.

Does your child suffer from any allergies?

If yes please provide passport size photo of child
 No Yes (Specify below)

To assist us look after your child should they have an allergic reaction whilst in our care please list the allergies your child has, the symptoms of the reaction and how you would like us to treat the reaction.

Allergy 1.

Allergy Description:

Allergy Treatment: Complete a medication form if you require staff to administer medication on your behalf

Allergy 2.

Allergy Description:

Allergy Treatment: Complete a medication form if you require staff to administer medication on your behalf

Asthma

Does your child suffer from Asthma?

If Yes, please provide child passport size photo
 No Yes (Specify below)

To assist us to look after your child should they have an Asthma attack whilst in our care please list the symptoms and how you would like us to treat the reaction. Please also provide details of any Asthma medication taken.

Symptoms:

Treatment:

Medication Taken: You must complete a medication form if you require staff to administer medication on your behalf.

Other Medical Conditions

Does your child suffer from any of the following medical conditions?

If yes please provide a passport size photo
 A D D A D H D Aspergers Syndrome
 Autism Epilepsy Learning Difficulty
 Phobias Physical Disability Intellectual Disability
 Heart Problems Sensory Impairment Behaviour Disorder

Other:

If you have indicated your child has a medical condition, please describe the condition and how you would like us to treat the condition.

Condition 1.

Description:

Treatment: You must complete a medication form if you require staff to administer medication on your behalf

Condition 2.

Description:

Treatment: You must complete a medication form if you require staff to administer medication on your behalf

Programs

Please tick which School Age Care program you would like to enrol your child into, remembering not all programs may be available at this service

BSC ASC VAC Teen Program

Booking Details

Please indicate which days you require care. See coordinator for Vacation Care booking details.

Before School Care	Mon <input type="checkbox"/>	Tue <input type="checkbox"/>	Wed <input type="checkbox"/>	Thu <input type="checkbox"/>	Fri <input type="checkbox"/>
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After School Care	Mon <input type="checkbox"/>	Tue <input type="checkbox"/>	Wed <input type="checkbox"/>	Thu <input type="checkbox"/>	Fri <input type="checkbox"/>
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Care to start on: / /

Additional Booking Information:

SCHOOL AGE CARE ADDITIONAL CHILD ENROLMENT FORM

Please request additional enrolment forms from coordinator if you are enrolling more than two children into the PCYC School Age Care Service.

Please complete this form if you wish to enrol your child (ren) into our School Age Care program. Please ensure all information is correct and where appropriate, corresponds exactly with information held by Centrelink.

Key Enrolment Information - Child 2

First Name: [text box]

Middle Name: [text box]

Last Name: [text box]

Child CRN: [text box]

(Example 322 323 611A (CRN - Customer Reference Number) - (You will be charged FULL FEE (No Government CCB assistance) if NO or UNRECOGNISED child CRN is provided)

Child's D.O.B [text box] / [text box] / [text box] dd/mm/yy Priority of Access [checkbox]

(You will be charged FULL FEE (No Government CCB assistance) if NO or UNRECOGNISED child D.O.B is provided. Please refer to your paper work from Centrelink for your priority of access number, alternatively contact Centrelink.

PCYC Membership # [text box] To be enrolled all children must be PCYC members

Gender: Female [checkbox] Male [checkbox]

Indigenous Status [checkbox] NOT Aboriginal OR Torres Strait Islander

[indicate which [checkbox] Aboriginal AND Torres Strait Islander

best describes [checkbox] Aboriginal NOT Torres Strait Islander

your child] [checkbox] Torres Strait Islander NOT Aboriginal

Religious/Cultural Requirements [checkbox] Does your child have any religious/cultural requirements?

If your child does have a cultural/religious requirement please provide passport size photo of your child

Photos -yes [checkbox] I authorize my child's photograph to be taken and used at the service, understanding I will be informed if it will be used for media purposes.

Swimming Ability Can't Swim [checkbox] Good Swimmer [checkbox]

Poor Swimmer [checkbox] Excellent Swimmer [checkbox]

Dietary Requirements [checkbox] Does your child have any special dietary requirements? Provide information below

If your child does have special dietary requirements please provide a passport size photo of your child.

[Large empty text box for dietary requirements photo]

Supplementary Enrolment Information

School Start Date [text box] / [text box] / [text box] (Approximate Date is sufficient)

School Attends: [text box]

City/Town of Birth: [text box]

Nationality: [text box]

Language spoken at home [text box]

Parenting Orders

Parenting Orders, previously know as Court Orders (Prior to Family Law Ac 1996) can include Parenting Plans, Parental Responsibility, Plans, Residence Orders and Contact Orders.

If you are separated / divorced, who has legal custody of your child?

Parent 1 [checkbox] Name: [text box]

Parent 2 [checkbox] Name: [text box]

Both [checkbox]

Are there any court orders relating to the powers and responsibilities of the parents in relation to the child or access to the child?

[checkbox] Yes (complete below) [checkbox] No

Parent 1 Access Arrangements

Full Time [checkbox] Arrangement Details: [text box]

Limited [checkbox]

Parent 2 Access Arrangements

Full Time [checkbox] Arrangement Details: [text box]

Limited [checkbox]

Health Details

Immunisation Status

Please mark this box if your child's immunisation status is up to date [checkbox] If your child's immunisation status is not up to date your eligibility to receive Government fee assistance through CCB may be affected [checkbox]

Allergies - If necessary continue on separate paper & provide a written treatment plan if one is available.

Does your child suffer from any allergies?

If yes please provide passport size photo of child No [checkbox] Yes (Specify below) [checkbox]

To assist us look after your child should they have an allergic reaction whilst in our care please list the allergies your child has, the symptoms of the reaction and how you would like us to treat the reaction.

Allergy 1. [text box]

Allergy Description: [text box]

Allergy Treatment: Complete a medication form if you require staff to administer medication on your behalf [text box]

Allergy 2. [text box]

Allergy Description: [text box]

Allergy Treatment: Complete a medication form if you require staff to administer medication on your behalf [text box]

Asthma

Does your child suffer from Asthma?

If Yes, please provide child passport size photo No [checkbox] Yes (Specify below) [checkbox]

To assist us to look after your child should they have an Asthma attack whilst in our care please list the symptoms and how you would like us to treat the reaction. Please also provide details of any Asthma medication taken.

Symptoms: [text box]

Treatment: [text box]

Medication Taken: You must complete a medication form if you require staff to administer medication on your behalf. [text box]

Other Medical Conditions

Does your child suffer from any of the following medical conditions?

If yes please provide a passport size photo A D D [checkbox] A D H D [checkbox] Aspergers Syndrome [checkbox]

Autism [checkbox] Epilepsy [checkbox] Learning Difficulty [checkbox]

Phobias [checkbox] Physical Disability [checkbox] Intellectual Disability [checkbox]

Heart Problems [checkbox] Sensory Impairment [checkbox] Behaviour Disorder [checkbox]

[checkbox] Other: [text box]

If you have indicated your child has a medical condition, please describe the condition and how you would like us to treat the condition.

Condition 1. [text box]

Description: [text box]

Treatment: You must complete a medication form if you require staff to administer medication on your behalf [text box]

Condition 2. [text box]

Description: [text box]

Treatment: You must complete a medication form if you require staff to administer medication on your behalf [text box]

Programs

Please tick which School Age Care program you would like to enrol your child into, remembering not all programs may be available at this service

BSC [checkbox] ASC [checkbox] VAC [checkbox] Teen Program [checkbox]

Booking Details

Please indicate which days you require care. See coordinator for Vacation Care booking details.

Before School Care Mon [checkbox] Tue [checkbox] Wed [checkbox] Thu [checkbox] Fri [checkbox]

After School Care Mon [checkbox] Tue [checkbox] Wed [checkbox] Thu [checkbox] Fri [checkbox]

Care to start on: [text box] / [text box] / [text box]

Additional Booking Information:

[Large empty text box for additional booking information]

Parent/Guardian Details

Parent 1: Details - Must be Account holder and person who is registered with FAO

First Name: [] Middle Name: [] Last Name: [] Relationship to child: [] Family CRN: [] Parent D.O.B [] / [] / [] dd/mm/yy

(You will be charged FULL FEE (No Government CCB assistance) if NO or UNRECOGNISED child CRN is provided. Please refer to your paper work from Centrelink for your priority of access number, alternatively contact Centrelink

Gender: Female [] Male []

Address: []

[]

Suburb: [] Postcode: []

Billing Address: []

[]

If same as address please write as above

Home Tele: []

Mobile Tele: []

Work Mobile: []

Email []

Would you like to receive the following via email?

Accounts [] Service Information [] Newsletters []

Please tick if your would like to receive this information in a language other then English: [] (specify language below)

[]

Parent 2: Details:

First Name: [] Middle Name: [] Last Name: [] Relationship to child: [] Parent D.O.B [] / [] / [] dd/mm/yy

Gender: Female [] Male []

Address: []

[]

Home Tele: []

Mobile Tele: []

Work Mobile: []

Email: []

Emergency Contact Order Please indicate order in which you would like staff to make contact in case of emergency:

Parent 1 [] Parent 2 [] If applicable Additional Contact 1 [] Additional Contact 2 [] Additional Contact 3 [] If applicable Additional Contact 4 [] If applicable

Child Summary

School Age Care Children:

Child (a) []

Child (b) []

Child (c) []

Additional Children - Children who attend Long Day Care/Family Day Care or in Home Care

Child (a) []

Child (b) []

Child (c) []

Additional Emergency Contact Details

Please nominate those who are authorised to collect or to be contacted in case of emergency in order of preference. Tick one or both boxes to nominate contact authorisations.

Details for Contact 1: Emergency Contact [] Authorised Pickup []

First Name: []

Last Name: []

Home Address: []

[]

Home Tele: []

Mobile Tele: []

Work Tele: []

Relationship to Child []

Details for Contact 1: Emergency Contact [] Authorised Pickup []

First Name: []

Last Name: []

Home Address: []

[]

Home Tele: []

Mobile Tele: []

Work Tele: []

Relationship to Child []

Details for Contact 3: Emergency Contact [] Authorised Pickup []

First Name: []

Last Name: []

Home Address: []

[]

Home Tele: []

Mobile Tele: []

Work Tele: []

Relationship to Child []

Details for Contact 4: Emergency Contact [] Authorised Pickup []

First Name: []

Last Name: []

Home Address: []

[]

Home Tele: []

Mobile Tele: []

Work Tele: []

Relationship to Child []

Medical Contacts

When seeking medical treatment, increasingly health professionals are requesting child care services provide the following information before treating a child. Please assist us provide timely treatment by providing the necessary information.

Medicare Number: []

Health Fund (if applicable) []

Doctors Surname []

First Name []

Surgery Address []

[] Post code []

Surgery Telephone: []

Parent/Guardian Involvement - We encourage parents/guardians to be involved in our programs. If you have any skills or hobbies you would like to share with the children in our care please list them below.

[]

General Permissions:

Please print full names, tick the appropriate boxes and initial each term and agreement. **Please be aware where a signature, initials or indication that agreement has not been read will result in your child's enrolment not being processed.**

Parent Name: (The parent/guardian of the following children)

Child 1 Name: Child 2 Name:

Child 3 Name: Child 4 Name:

- | <input checked="" type="checkbox"/> Terms | Initial |
|--|---------|
| <input type="checkbox"/> I have read and understand and agree to abide by the conditions stated in the latest edition of the Parent Handbook | _____ |
| <input type="checkbox"/> Agree to familiarize myself with the programs and inform staff if I do not wish for my child (ren) to participate in a particular activity | _____ |
| <input type="checkbox"/> If applicable understand my child (ren) will be transported by bus or walk to and from school and excursions and I understand that when fitted, my child will be required a seat belt. Children under 7 will be provided with a booster seat in a vehicle with 12 or less seats | _____ |
| <input type="checkbox"/> Give permission for staff to apply sunscreen (30+) If my child has an allergy, I agree to provide suitable sunscreen for my child | _____ |
| <input type="checkbox"/> Consent PCYC staff providing: a) First Aid, or where appropriate, b) administering such emergency medical treatment as is reasonable necessary; c) seeking medical attention, and that I will reimburse any necessary expenses incurred by the service. | _____ |
| <input type="checkbox"/> Agree to collect or make arrangements for collection of my child (ren) if he/she becomes unwell at the service. | _____ |
| <input type="checkbox"/> Agree to inform the School Age Care Service of other children attending Long Day Care/Family Day Care/In Home Care or any other service where CCB is provided. I must notify the School Age Care Service of any child changes that may occur. | _____ |
| <input type="checkbox"/> Consent for PCYC School Age to share/attain information with my child('s) School Administration and staff on issues pertaining to my child | _____ |
| <input type="checkbox"/> I understand that CCB is payable for only 42 allowable absence each year and authorise the PCYC to record an allowable absence on any day my child (ren) is/are enrolled but does not attend, unless I provide a valid reason (according to Government requirements). | _____ |
| <input type="checkbox"/> Agree to pay all fees (including excursion fees) of the days my child is successfully enrolled, regardless of whether my child is enrolled but does not attend. I agree that 48 hours notice of non-attendance must be given otherwise I will be charged for the booked sessions. | _____ |
| <input type="checkbox"/> Understand that fees are due and payable a minimum of one week in advance at all times, and I may be required to enter into a payment plan using our prescribed third party company iDebit, if my fees are not paid by the due date or if I get in arrears | _____ |
| <input type="checkbox"/> Understand that my child (ren) care can be cancelled if my fees fall into arrears by more then 7 days and I agree to pay all outstanding costs, including legal expenses, incurred by the service to collect payment of outstanding fees. | _____ |
| <input type="checkbox"/> Agree to pay a minimum of one week's gap fee upfront upon enrolment for BSC and ASC and fees are requested a minimum of two weeks upfront for VAC care prior to my child (ren) commencing attendance. | _____ |
| <input type="checkbox"/> Understand that in the event my child (ren) is sent home with a suspected infectious illness a medical clearance/certificate must be provided on return of my child (ren) to the service | _____ |
| <input type="checkbox"/> (If applicable) give permission for my child (ren) to play, under supervision, on the school-oval and/ or local park. | _____ |
| <input type="checkbox"/> Should staff arrive at school to collect my child (ren) and the child (ren) is/are not in the designated area and I have not informed the service of my child (ren) absence, agree to pay a \$2.00 fee will be charged to my account for each telephone call that is made to discover the whereabouts of my child (ren) | _____ |
| <input type="checkbox"/> Understand that my child (ren) maybe required to leave the service because of priority access considerations as detailed in section 6.3 – pages 67-68 of the Child Care Service Handbook 2010-2011 (Australian Government, Dept of Families and Community Services). | _____ |

Parent/Guardian Signature

Parent Signature: Date:

Print Name:

Induction Information

Please check to ensure that you have received all the relevant information when enrolling your child into our services.

- Parent Handbook Session Times Fees and Cost PCYC Membership All About Me Booklet
- iDebit Application Service Newsletter SAC Booking Form QA Information Booklet



Application for Membership

Member Details

_____ / / _____ M / F
 First name Middle name/initial Family Name Date of birth Gender

 Street N° Street Suburb Post code

 Home Phone N° Work N° (if applicable) Mobile N° (if applicable)

 Email address _____

 Occupation School or College Grade or Level

 Activities in which the applicant will participate Describe any Activity in which the applicant should **NOT** participate

Describe any relevant illness/allergies from which the applicant suffers

NB. If there are any relevant existing custody issues please attach details

Emergency Information (who should we contact if there is an accident or other emergency?)

 First Name Family Name Relationship

 Home Phone N° Work N° Mobile N° (if applicable)

 Doctor's Name / Contact N° _____

I authorise / do not authorise the PCYC to take and use any photographs, videos or sound recordings of me/ the child and any other reproductions or adaptations of my/the child's likeness ("the Material"), either in full or part, in conjunction with any wording or drawings, in any PCYC publications, productions or presentations. I acknowledge that I have/ the child has no rights in the material or in any PCYC publications, productions or presentations that include the material.

I hereby certify the particulars I have provided are correct and I accept the conditions of clauses 1-4 which are detailed overleaf

_____ / ____ / _____
Applicant (18 years and over) or Parent/Guardian (for child) Date

Are you willing to volunteer your skills or time to the PCYC? YES NO
 If yes: coaching administration other (please specify) _____
 cleaning gardening

N.B. Membership is valid for all PCYC Branches in Queensland

Conditions of Membership

Please sign overleaf that you accept these conditions;

1. I certify that the particulars provided overleaf are true and correct, and that I am willing (for the applicant) to become a member of the QPCYWA. I acknowledge that the Association is a drug-free environment and that the use of prohibited drugs will automatically result in cancellation of membership and expulsion from Association premises.
2. I/we the applicant/parent(s)/legal guardian acknowledge that all activities entered into by myself/my child/my ward contain an element of risk and I/my child/my ward must take reasonable care whilst participating in any activities offered by the Association.
3. I/we authorise the Association to obtain all necessary medical treatment which may be required by me/the member whilst in the custody, care or control of the Association. I/we acknowledge that the costs of any such treatment shall be my/the member's responsibility solely.
4. I/we authorise the Association to exercise all reasonable discipline without physical punishment necessary in circumstances over the member whilst in the custody, care or control of the Association, including the right at the Association's absolute discretion to return me/the member to my/their home address stipulated on the application form.

Office Use Only

	Year 1	Year 2
Member Number	<input type="text"/>	<input type="text"/>
	Year 1	Year 2
Member Class	<input type="text"/>	<input type="text"/>
	Year 1	Year 2
Process Date	<input type="text"/>	<input type="text"/>
	Year 1	Year 2
Receipt Number	<input type="text"/>	<input type="text"/>
	Year 1	Year 2
Barcode Number	<input type="text"/>	<input type="text"/>
	Year 3	Year 4
Member Number	<input type="text"/>	<input type="text"/>
	Year 3	Year 4
Member Class	<input type="text"/>	<input type="text"/>
	Year 3	Year 4
Process Date	<input type="text"/>	<input type="text"/>
	Year 3	Year 4
Receipt Number	<input type="text"/>	<input type="text"/>
	Year 3	Year 4
Barcode Number	<input type="text"/>	<input type="text"/>
	<input type="text"/>	
	Supervisor/Staff Signature	

Year 2 ENDORSEMENT	Year 3 ENDORSEMENT	Year 4 ENDORSEMENT
I have checked this membership form and made any necessary adjustments (specified below).	I have checked this membership form and made any necessary adjustments (specified below).	I have checked this membership form and made any necessary adjustments (specified below).
I certify that the information supplied on this membership form is true and correct.	I certify that the information supplied on this membership form is true and correct.	I certify that the information supplied on this membership form is true and correct.
Member/Parent/Guardian	Member/Parent/Guardian	Member/Parent/Guardian
Supervisor/Staff	Supervisor/Staff	Supervisor/Staff

DIRECT DEBIT REQUEST / CREDIT CARD AUTHORITY



**PCYC
Yeppoon**



New Direct Debit Request	<input type="checkbox"/>	Amendment to Direct Debit Request	<input type="checkbox"/>	iDebit Client Reference
New Credit Card Authority	<input type="checkbox"/>	Amendment to Credit Card Request	<input type="checkbox"/>	2543
Family ID		Alternate Reference		

Request and Authority to debit the account named below.

Surname	Christian names "YOU"
Postal Address	
Mobile	Email Address

Please complete **BOTH** Section 1 Direct Debit Request & Section 2 Credit Card Authority

Section 1 Direct Debit Request **Primary** **Secondary**

Financial Institution Name	BSB	Account Number
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Address of Financial Institution

Account Holder's Name

Signature of Account Holder	Signature of Account Holder
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Please note if account is joint both signatures are required

You request and authorise Indue Limited ("Indue") ABN 97 087 822 464 (User ID 360369) to debit funds from the nominated account identified in this Section 1 through the Bulk Electronic Clearing System ("BECS") in accordance with this Direct Debit Request and the terms and conditions set out in the Direct Debit Request Service Agreement & Credit Card Authority Service Agreement. *You acknowledge and agree that for each Debit Payment Indue debits from your nominated account identified in this Section 1, you will be charged an additional transaction fee of \$0.77. You authorise Indue to debit this additional fee from the nominated account identified above at the same time Indue debits each Debit Payment.*

Section 2 Credit Card Authority **Primary** **Secondary**

Credit card details	Expiry Date
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Cardholder's Name	Cardholder's Signature
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You request and authorise Indue Limited ("Indue") ABN 97 087 822 464 to debit funds from the credit card account identified in this Section 2 in accordance with this Credit Card Authority and the terms and conditions set out in the Direct Debit Request Service Agreement & Credit Card Authority Service Agreement. You acknowledge and agree that for each Debit Payment Indue debits from the credit card identified in this Section 2 you will be charged an additional transaction fee of 1.50% of the total value of your Debit Payment. You authorise Indue to debit this additional fee from the credit card identified above at the same time Indue debits each Debit Payment.

Section 3 Payment Schedule

First Debit Date	First Debit Amount
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Or for any such other amount/s or period/s as directed by you to Indue or the Business from time to time in accordance with the fee schedule or contract provided by the Business to you. In circumstances where there are insufficient funds in your Account to meet a Debit Payment you authorise Indue to re-process any unsuccessful Debit Payment.

Section 4 Payment Period

Weekly **F/nightly** **Monthly** **If no payment period is specified then default to weekly.**

You acknowledge and agree that you will be charged an initial establishment fee of \$2.20. You authorise Indue to debit this establishment fee from the Account on the First Debit Date.

By signing this Direct Debit Request/Credit Card Authority you acknowledge that you have read and understood the terms and conditions under which debit arrangements are made between you and Indue in this Direct Debit Request/Credit Card Authority and the direct Debit Request Service Agreement & Credit Card Authority Service Agreement and agree to be bound by them.

The definitions of words that are capitalised are explained in the Direct Debit Request Service Agreement & Credit Card Authority Service Agreement.

DIRECT DEBIT REQUEST / CREDIT CARD AUTHORITY

Indue Limited ABN 97 087 822 464
Level 3, 601, Coronation Drive, Toowong QLD 4066
PO Box 523, Toowong QLD 4066
Phone 1300 433 248 Fax (07) 3258 3449

Direct Debit Request Service Agreement & Credit Card Authority Service Agreement

This is your Direct Debit Request Service Agreement & Credit Card Authority Service Agreement with Indue Limited ABN 97 087 822 464 (Debit User ID 360369). It explains what your obligations are when undertaking a Direct Debit arrangement with us. It also details what our obligations are to you as your direct debit provider.

Please keep this Agreement for future reference. It forms part of the terms and conditions of your Direct Debit Request / Credit Card Authority and should be read in conjunction with the authorisations you provided to us in the Direct Debit Request / Credit Card Authority.

Definitions	<p>Account means the account and/or credit card account held at Your Financial Institution from which we are authorised to arrange for funds to be debited.</p> <p>Agreement means this Direct Debit Request Service Agreement & Credit Card Authority Service Agreement between you and us.</p> <p>Business means Queensland Police Citizens youth Welfare Association. ACN 009666193.</p> <p>Business Day means a day other than a Saturday or Sunday or a national public holiday.</p> <p>Indue means Indue Ltd ABN 97 087 822 464.</p> <p>Debit Day means the day that you have authorised us to arrange for funds to be debited from your Account.</p> <p>Debit Payment means a particular transaction where a debit is made.</p> <p>Direct Debit refers to the process whereby you provide us with the Direct Debit Request / Credit Card Authority which authorises us to arrange for funds to be debited from an account held with Your Financial Institution or from your credit card.</p> <p>Direct Debit Request / Credit Card Authority means the Direct Debit Request / Credit Card Authority between you and us.</p> <p>First Debit Amount means the amount inserted by you on the Direct Debit Request / Credit Card Authority, which records the first amount that you authorise us to debit from your Account.</p> <p>First Debit Date means the date inserted by you on the Direct Debit Request / Credit Card Authority, which records the date that you authorise us to debit the First Debit Amount from your Account.</p> <p>Regular Debit Date means the date inserted by you (if applicable) on the Direct Debit Request / Credit Card Authority, which records the date you authorise us to debit the Regular Debit Amount from your Account.</p> <p>Total Debit Amount means the total amount inserted by you (if applicable) on the Direct Debit Request / Credit Card Authority that you authorise us to debit from your Account whilst you have this Agreement with us.</p>
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Definitions	<p>Us or we means Indue, that you have authorised by requesting a Direct Debit Request / Credit Card Authority.</p> <p>You means the customer who signed or authorised by other means the Direct Debit Request / Credit Card Authority.</p> <p>Your financial institution is the financial institution nominated by you on the Direct Debit Request / Credit Card Authority at which your Account is maintained.</p>
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Debiting your Account	<p>By signing the Direct Debit Request / Credit Card Authority or providing us with a valid instruction, you have authorised us to arrange for funds to be debited from your Account. You should refer to the Direct Debit Request / Credit Card Authority and this Agreement for the terms of the arrangement between us and you.</p> <p>We will only arrange for funds to be debited from your Account as authorised in the Direct Debit Request / Credit Card Authority.</p> <p>Indue will, in the first instance, debit (deduct) the Debit Payment from the Account nominated by you in the Direct Debit Request as being the primary Account. If there are insufficient funds in your primary Account to meet a Debit Payment, you authorise Indue to re-process any unsuccessful Debit Payment. Indue will, in the first instance, attempt to re-process the Debit Payment to the Account nominated by you on the Direct Debit Request, as being the primary Account. If the re-processing of that Debit Payment is unsuccessful, you authorise Indue to debit (deduct) that Debit Payment from the Account nominated by you in the Direct Debit Request as being the secondary Account.</p> <p>If the Debit Day falls on a day that is not a Business Day, we may direct Your Financial Institution to debit your Account on the following Business Day. If you are unsure about which day your Account has or will be debited you should ask Your Financial Institution.</p>
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Business	<p>By signing the Direct Debit Request / Credit Card Authority you acknowledge that we are acting as a third party payment processor for the Business to arrange for the funds to be debited from your Account. Accordingly, you agree to pursue all claims you have in respect of the goods and services provided to you by the Business or the terms and conditions of any agreement entered into between you and the Business against the Business. As Indue does not supply the goods or services that relate to the payments it processes for the Business, you agree not to pursue Indue in respect of any claim you may have in respect of the quantity, the quality or the merchantability of those goods or services supplied by the Business.</p>
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Changes by you	<p>It you wish to stop or defer a Debit Payment or terminate this Agreement, you must notify us at least seven (7) Business Days before the next Debit Day. This notice should be given to the Business in the first instance by telephoning the Business on (07) 3909 9555 during business hours or providing written notice to the Business at 61 Southgate Avenue, Cannon Hill. Qld. 4170</p> <p>Alternatively you may:</p> <ul style="list-style-type: none">• write to us at PO Box 523, Toowong, QLD 4066;• telephone us on 1300 433 248; or• arrange it through Your Financial Institution, which is required to act promptly on your instructions.
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Your obligations	<p>It is your responsibility to ensure that there are sufficient clear funds available in your Account to allow a Debit Payment to be made in accordance with the Direct Debit Request / Credit Card Authority.</p> <p>If there are insufficient funds in your Account to meet a Debit Payment:</p> <ul style="list-style-type: none">• you may be charged a fee and/or interest by Your Financial Institution; and
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DIRECT DEBIT REQUEST / CREDIT CARD AUTHORITY

- you must arrange for the Debit Payment to be made by another method or arrange for sufficient cleared funds to be in your Account by an agreed time so that we can process the Debit Payment.
- you authorise Indue to re-process any unsuccessful Debit Payment.

You should check your account statement to verify that the amounts debited from your Account are correct.

Disputes	<p>If you believe that there has been an error in debiting your Account, you should notify the Business in the first instance and confirm that notice in writing with the Business as soon as possible so that the Business can resolve your query more quickly. If the Business cannot resolve the matter or you are not satisfied with the Business's handling of the matter, you may contact us directly on 1300 433 248. Alternately you can take it up directly with Your Financial Institution.</p> <p>If we conclude, as a result of our investigations, that your Account has been incorrectly debited we will respond to your query by arranging for Your Financial Institution to adjust your account (including interest and charges). We will also notify you in writing of the amount by which your Account has been adjusted.</p> <p>If we conclude as a result of our investigations that your Account has not been incorrectly debited we will respond to your query by providing you with reasons and any evidence for this finding in writing.</p> <p>If we cannot resolve the matter or you are not satisfied with our proposed resolution, you can still refer it to Your Financial Institution which will obtain details from you of the disputed transaction and may lodge a claim on your behalf.</p>
Accounts	<p>You should check:</p> <ul style="list-style-type: none">• with Your Financial Institution whether direct debiting is available from your Account as direct debiting is not available on all accounts offered by financial institutions;• your Account details which you have provided to us are correct by checking them against a recent account statement; and• with Your Financial Institution before completing the Direct Debit Request / Credit Card Authority if you have any queries about how to complete the Direct Debit Request / Credit Card Authority.
Confidentiality	<p>We will keep any information (including your Account details) in your Direct Debit Request / Credit Card Authority confidential. We will make reasonable efforts to keep any such information that we have about you secure and to 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.</p> <p>We will only disclose information that we have about you:</p> <ul style="list-style-type: none">• to the extent specifically required by law;• to the Business; or• for the purposes of this Agreement (including disclosing information in connection with any query or claim).
Notice	<p>If you wish to notify us in writing about anything relating to this Agreement you should write to Indue, PO Box 523, Toowong Qld 4066.</p> <p>We will notify you by sending a notice in the ordinary post to the address you have given us in the Direct Debit Request / Credit Card Authority.</p> <p>Any notice will be deemed to have been received two Business Days after it is posted.</p>

About Me

What's the best thing about the PCTYC?

If I went home after school I would like to?

My favourite, healthy food is:

Tick if you like Watching videos

My favourite sport is?

Tick if you like art

My favourite outside activity?

I would like to learn more about?

The three things I am good at doing are:

Tick if you like board games

My favourite inside activity?

Tick if you like cooking

Tick if you like outside play

What would be a cool excursion?

What do you like to do that's quiet?

What would you like to cook?

Tick if you like Drama



QPCYWA

Queensland Police Citizens Youth Welfare Association

Teaching Tolerance

Anti-Bulling Pledge







We the students of _____

Agree to join together to STOP bullying.

Name: _____

Date of Birth: _____

BY SIGNING THIS PLEDGE I AGREE TO:

-  Treat others respectfully.
-  Try to include those who are left out.
-  Refuse to bully others
-  Refuse to watch, laugh or join in when someone is being bullied
-  Tell an adult
-  Help those who are being bullied

Signed by _____

Date _____

Coordinator _____