



What to Bring Daily

NURSERY- Please ensure all child's belongings are clearly labelled

- # Bottles
- # Food
- # Nappies for the day, or carton until nappies run out
- # Spare changes of clothes
- # Dummy- if child has a dummy
- # Teething rusks if child is teething
- # Hat

TODDLER- Please ensure all child's belongings are clearly labelled

- # Bottles/ Drink bottle
- # Morning Tea
- # Lunch
- # Afternoon Tea
- # Nappies for the day, or carton until nappies run out
- # LOTS of underwear if toilet training
- # Sheet/ Blanket for rest time
- # Spare change of clothes
- # Hat

KINDY/ PRESCHOOL- Please ensure all child's belongings are clearly labelled

- # Drink bottle
- # Morning Tea
- # Lunch
- # Afternoon Tea
- # Hat
- # Sheet for Rest time
- # Spare change of clothes

**Please note that Sheridan Meadows Child Care Centre promotes healthy eating. We encourage families to pack their child/ren a healthy and nutritious lunch daily.*

**Sheridan Meadows Child Care Centre also has a NO NUTS policy. We discourage families from bringing any peanut products into the centre. This includes; peanut butter, peanuts/ nuts, food containing peanuts/ nuts and nutella.*

We thank you for your co-operation.

Enrolment Form



Office Use Only

Date of Commencement: _____

Age at Commencement: _____

Group: _____

Priority: _____

Initial Enrolment Days

MON TUES WED THURS FRI

Entered By: _____

Cnr Progress Road and Fretwell Road
White Rock, Qld, 4869

Child's Details

Family Name: _____	Given Names: _____
Address: _____	_____
_____	Date of Birth: _____
_____	Male / Female

Parent/Guardian Details

To be contacted in the case of illness or other incident? Yes/No

Name: _____

Address: _____

Home Phone Number: _____

Occupation: _____

Work Address: _____

Work Phone Number: _____

Mobile Number: _____

E-mail Address: _____

Language spoken at home: _____

Days contactable at work:
Mon Tues Wed Thurs Fri

Parent/Guardian Details

To be contacted in the case of illness or other incident? Yes/No

Name: _____

Address: _____

Home Phone Number: _____

Occupation: _____

Work Address: _____

Work Phone Number: _____

Mobile Number: _____

E-mail Address: _____

Language spoken at home: _____

Days contactable at work:
Mon Tues Wed Thurs Fri

Emergency Contacts (Other than Parent)

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone: _____	Phone: _____
Is this person authorised to collect your child? Yes/No	Is this person authorised to collect your child? Yes/No

Attendance

Days Required for care (including estimated times):

Monday

Tuesday

Wednesday

Thursday

Friday

_____ - _____ _____ - _____ _____ - _____ _____ - _____ _____ - _____

Requested Starting Date:

Reason For Care:

If your child has attended another approved childcare facility during this financial year, please indicate the number of allowable absences your child has used this financial year. If you are unsure of this information, please inform us of the name of the childcare facility so that we may follow this through.

Days absent:

Name of the childcare facility/facilities:

If your child will be attending another childcare facility whilst also attending this facility, please advise us of this facility.

Name of additional childcare facility: _____

Days in attendance at alternative facility:

Monday

Tuesday

Wednesday

Thursday

Friday

**If you would like to discuss this with our administrator, please do not hesitate to speak with them.

If you have children attending other facilities, including After School Care, Family Day Care, school or a different child care facility, please list them:

Child's Name:

Facility attended:

_____	_____
_____	_____
_____	_____
_____	_____

Special Circumstances

Please list any special requirements your child may have e.g. cultural or religious practices, disability, special needs, or other:

Does your child live with both parents?

Yes / No

If NO, Are there current court orders in place?

*Yes / No

**A copy of the Court Order is required*

According to Family Law, access by non-custodial parent cannot be denied unless a current copy of legal documents regarding Residency and Access are kept on site at Sheridan Meadows Child care Centre.

Medical Information

Doctor's Name	Address:
Doctor's Phone Number:	Medicare Number:
If your child has a disability or diagnosed condition, please indicate it here:	
Special Requirements (medication times/dosage(s), exercises, physical restrictions etc):	
Does your child suffer from Asthma? Yes / No <i>If yes, please complete an Asthma Management Plan upon notification of placement at BPCCC.</i>	
Is there any relevant information regarding the pregnancy/birth of your child? (premature birth, trauma etc)	
Please indicate any allergies associated with your child:	

Signed: _____ Signed: _____
Parent/Guardian Parent/Guardian

I/We _____ have read and understood the policies contained in this form and the Sheridan Meadows Child Care Centre's Handbook.

I/We agree to abide by these policies.

Signed: _____ Signed: _____
Parent/Guardian Parent/Guardian

* The Department of Communities is the Governing body for Sheridan Meadows Child Care Centre. If you have any concerns you wish to discuss with The Department of Communities, please call (07) 40489311.

Authorities

Permission for local excursions

I do/do not (please circle) agree to allow my child to be taken to the shops or postbox in the immediate vicinity of Sheridan Meadows Child Care Centre, as part of their program and activities. I understand that staff/child ratio as required by regulations will be adhered to.

Permission for van excursions

I do/do not (please circle) agree to allow my child to be taken on excursions in the van as part of their program and activities. I understand that staff/child ratio as required by regulations will be adhered to.

NOTE: You will be notified of details of the excursion beforehand and will be required to give verbal or preferably written permission.

Restraints: standard seat belts and booster seats on the left and right seat in the middle and back rows. Harnesses are used on both the middle seats.

Immunizations

I accept that it is my responsibility to ensure that Sheridan Meadows Child Care Centre has an up-to-date record of my child's immunization.

I understand that my child may be excluded from the centre for the recommended exclusion period, if another child contracts one of the illnesses for which there is immunization when the Centre holds no record for my child.

Sunscreen

I do/ do not (please circle) authorize the staff of Sheridan Meadows Child Care Centre to apply sunscreen (recommended by Qld Cancer Council) to my child.

Insect Repellant

I do/ do not (please circle) authorize the staff of Sheridan Meadows Child Care Centre to apply insect repellant to my child as necessary.

Photographs

I do/ do not (please circle) agree to photographs of my child being taken for Centre use for newspaper articles, Sheridan Meadows Website and Publicity.

Paracetamol

I do/ do not (please circle) authorize the administration of paracetamol in the event of illness / accident. I understand that staff with First Aid qualifications will administer emergency First Aid in the event of illness /accident.

Band aids / Strapping

I do/ do not (please circle) authorise the application of adhesive bandages or other strapping in the event of an accident. I understand that staff with First Aid qualifications will administer First Aid in the event of an accident.

Ambulance / Medical Treatment

I understand that if medical, hospital or ambulance services are used if neither parent nor emergency contact can be located, I will be liable for the cost.

Cheeky Monkey & Puppet Learn and Play

I would/would not (Please Circle) like my child to participate in Cheeky Monkey and Puppet Learn and Play when scheduled.

I do/ do not (Please Circle) give Sheridan Meadows permission to add the \$5 fee to my account.

Fees

I agree to pay the required fees under the conditions set out in the Parent Handbook while my child attends Sheridan Meadows Child Care Centre

Signed:
(Parent/Guardian) _____



Asthma Record Form

Child's Name:

Age:

Date of Birth:

Contact for parents:

Parent / Carer One

Parent / Carer Two

Doctor's name and contact number:

What are your child's usual symptoms: (circle)

Wheezing

Coughing

Difficulty with breathing

Tightness in chest

Breathing problems with exercise

Other: _____

Medications – what does your child take when he/she has an asthma attack at home?

Medication:

How often:

What medication (supplied by parent/carer) is to be used when your child gets asthma symptoms at the Centre:

Medication:

Method used: (puffer / spacer)

Dosage: (4 puffs?)

Does your child need asthma medication before exercise?

Yes / No

Medication:

Method used: (puffer / spacer)

Dosage: (4 puffs?)

Will your child require asthma medication every day at this Centre?

Yes / No

Medication:

Method used: (puffer / spacer)

Dosage: (4 puffs?)

Any other relevant information (eg asthma triggers, allergies, arrangements for excursions, side effects from asthma medication).

Note: if your child needs to take any additional asthma medication (eg for a few days after an asthma attack) please complete an Administration of Medication form.

Name of Parent:

Signature of parent:

Date:



Allergy Form

Name of child: _____

Date of birth: _____

Does your child have ANY allergies? YES NO

If yes, please give SPECIFIC details: _____

What are your child's USUAL SIGNS and SYMPTOMS when exposed to an allergy-causing agent/food? _____

How soon does your child usually display these symptoms? (Please circle)

Immediately / 5-10 minutes / 10 – 20 minutes / 20 - 30 minutes / Within a few hours / Varies

Please outline the procedure for staff at Sheridan Meadows Child Care Centre to follow if your child is exposed to allergy-causing food/agent:

Can you give us any other information that you feel is relevant:

Please attach your child's management plan and/or the written instructions as given by his/her medical practitioner to this form.

Name of Medical Practitioner: _____ **Contact number:** _____

I hereby consent to the staff of the Sheridan Meadows Child Care Centre obtaining Ambulance Services and conveyance to the hospital in accordance with the Sheridan Meadows Child Care Centre Emergency Action Plan for my child if they are unable to contact any of the persons listed on the telephone numbers provided on the Emergency Action Plan

Signed _____ **(Parent/ Carer)** **Date** _____

Attach Action Plan Here



Parent Verification of Understanding Contents of Parent Handbook

Dear Parent,

Thank you for reading the Parent Handbook. Please fill in the details below, to confirm that you have read and understand the Parent Handbook.

This form will be kept with your child's records.

Thank you

Child's Name:

Date:

Parent's Name:

Parent's Signature:

Staff Name:

Staff Signature:

Position:

Date:

Communication to Staff

Please complete this form to ensure that this important, child specific information reaches your child's Group Leader. Please return the form prior to your child commencing at the centre, so that we may familiarize ourselves with your child's history and family.



Child's Details

Child's Name: _____	Nicknames: _____
Days of attendance: M T W Th F _____	Hours: _____
Date of Birth: _____	Male / Female

Mother's Details

Father's Details

Name: _____	Name: _____
Occupation: _____	Occupation: _____

Family Detail's

Names of siblings: _____	Ages _____
_____	_____
Names of pet(s) _____	Type of Pet _____
_____	_____

Special Interests

Does your child have any special interests? If yes, please highlight them here for your Group Leader, so that every effort can be made to assist in a smooth transition to day care for your child. Interests can include favorite activities (sandplay, painting, cars, etc.), favorite characters (Bob the Builder, Thomas the Tank engine, etc.) and favorite stories.

Health

Has your child suffered from any of the following minor illnesses? If yes, please indicate approximately how long ago your child suffered from the illness, the severity, and course of action you took.

Illness	How long ago?	Mild / Mod / Severe	Action Taken
Head Cold(s)	_____	Mild / Mod / Severe	_____
Ear Infection(s)	_____	Mild / Mod / Severe	_____
Vomiting	_____	Mild / Mod / Severe	_____
Diarrhoea	_____	Mild / Mod / Severe	_____
Other	_____	Mild / Mod / Severe	_____

Has your child suffered from any serious illnesses / accidents / operations? Yes / No
If Yes, please indicate below, any relevant information that staff may need to know.

Is your child currently taking any regular medication? Yes / No

If yes, please indicate below the medication name, required dosages, and times for administration.

Please note, for prescription medication, labels are to be clearly visible with doctor's instructions.

Medication Name:	Dosage:	Times:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child suffer from Asthma? Yes / No
If yes, Please fill out the Asthma Record

Other Relevant Information

Please indicate if you have any other relevant information that may assist in the smooth transition for your child to day care life. Indicate also if there are any specific issues the staff may need to be aware of in terms of residency issues etc, so that staff may be aware of reasons for mood changes etc. Other relevant information may include dietary restrictions and sleep patterns.

SIDS Policy

If your child has specific sleeping habits that are contrary to the SIDS recommendations and you want staff to follow your child's pattern, the following form **MUST** be completed. This will relieve the Sheridan Meadows Child Care Centre of any responsibility relating to your child's sleeping habits.

Should you wish to change your child's sleeping habits to follow the SIDS recommendations, please let the Nursery staff know so that they can support you and your child through this process of change.

Sleeping Habits Contrary to the SIDS Policy

I Understand that the Sheridan Meadows Child Care Centre Nursery follows the current SIDS recommendations. I am aware of these procedures and have viewed the relevant documentation.

My child **DOES NOT** follow these recommendations.

Child's Name: _____

The following is a description of how my child is put down to sleep.

Please put my child to sleep in this way while he/she attends the nursery at the Sheridan Meadows Child Care Centre.

By requesting the above, I understand that I waive the Centre's responsibility for staff settling my child to sleep in the way that I have chosen.

Parent / Guardian Name: _____

Parent / Guardian Signature: _____ Date: _____



Sleep Survey

Child's Name: _____

To assist us with the orientation of all children, we would appreciate a few minutes of your time in completing the following brief questionnaire.

Does your child require a sleep after lunch? Yes / No

Does your child (Over 2 years only) require a comfort toy or similar for sleep/ rest? Yes / No

If yes, please give details; _____

Does your child require particular clothing for rest? Yes / No

If yes, please give details; _____

If yes, please leave these in his/ her bag and staff will assist your child to access them at rest Yes / No

time. Please label all items clearly.

Is there a maximum time you would like to rest? Yes / No

If so, how long? _____

What is the latest we can put your child to sleep? _____

If your child is finding it difficult to fall asleep we will allow them to rest for an acceptable period of time, and try them at a later time if they still show signs of being tired.

Is this appropriate for your child? Yes / No

If no, what methods would you prefer we implement to ensure our child has adequate sleep/ rest during the day? _____

Does your child wear nappies for sleep time? Yes / No

Does your child require assistance to fall asleep? Yes / No

What methods would you prefer us to use? _____

Thank you for your assistance.



Toileting Survey

Child's Name: _____

To assist us with the transition of all the children within our centre and the orientation of all our new children, we would appreciate a few minutes of your time in completing the following brief questionnaire.

Does your child have nappies throughout the day? Yes / No

If no, does your child have a nappy for sleep time? Yes / No

If your child is in a sleep nappy you are required to provide a disposable nappy for this purpose.

Is your child showing an interest in toilet training? Yes / No

If so, are there any instructions? Yes / No

Is your child independent with toilet use? Yes / No

Comments; _____

Thank you for your assistance.



All about me, because I am Special!

To help my new friends get to know me, here are some things that make me special.....

My name is: _____

The name I prefer to be called is: _____

My home language is: _____

Special Names I have for my Mother: _____

Special Names I have for my Father: _____

The special name I call my Grandparents: _____

The names of my best friends: _____

The things I do well: _____

The things I enjoy: _____

My Favourite Food is: _____

Food I don't like: _____

My favourite toy is: _____

Songs I enjoy singing: _____

I have a pet Yes / No

My Pet is a _____ Named; _____

Any worries or fears I have: _____

How I communicate (eg; words, singing): _____

Other interesting thing about ME: _____



SHERIDAN MEADOWS

Child's Name: _____ Date: _____ Date of Birth: _____

My child is interested in learning:

At home my child is interested in:

Books & Music my child enjoys:

Outdoors my child enjoys:

People who are special to my child:

How you can help my child:



Immunisation Record Form

Child's Name: _____ Date: _____ Date of Birth: _____

Recommended age	Vaccines given (Please mark with an X)	Date of immunisation	X if given overseas
Birth	Engerix-B <input type="checkbox"/> HBVax II <input type="checkbox"/>	/ /	<input type="checkbox"/>
2 months	Infanrix <input type="checkbox"/> InfanrixHepB <input type="checkbox"/> Infanrix Hexa <input type="checkbox"/> Infanrix IPV <input type="checkbox"/> Infanrix Penta <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Pediacel <input type="checkbox"/> Poliacel <input type="checkbox"/> Quadracel <input type="checkbox"/> Tripacel <input type="checkbox"/>	/ /	<input type="checkbox"/>
	IPOL <input type="checkbox"/> Oral Polio <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Comvax <input type="checkbox"/> PedvaxHIB <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Prevenar <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Rotarix <input type="checkbox"/> RotaTeq <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Other (please specify)	/ /	<input type="checkbox"/>
4 months	Infanrix <input type="checkbox"/> InfanrixHepB <input type="checkbox"/> Infanrix Hexa <input type="checkbox"/> Infanrix IPV <input type="checkbox"/> Infanrix Penta <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Pediacel <input type="checkbox"/> Poliacel <input type="checkbox"/> Quadracel <input type="checkbox"/> Tripacel <input type="checkbox"/>	/ /	<input type="checkbox"/>
	IPOL <input type="checkbox"/> Oral Polio <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Comvax <input type="checkbox"/> PedvaxHIB <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Prevenar <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Rotarix <input type="checkbox"/> RotaTeq <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Other (please specify)	/ /	<input type="checkbox"/>
6 months	Infanrix <input type="checkbox"/> InfanrixHepB <input type="checkbox"/> Infanrix Hexa <input type="checkbox"/> Infanrix IPV <input type="checkbox"/> Infanrix Penta <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Pediacel <input type="checkbox"/> Poliacel <input type="checkbox"/> Quadracel <input type="checkbox"/> Tripacel <input type="checkbox"/>	/ /	<input type="checkbox"/>
	IPOL <input type="checkbox"/> Oral Polio <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Prevenar <input type="checkbox"/>	/ /	<input type="checkbox"/>
	RotaTeq <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Other (please specify)	/ /	<input type="checkbox"/>
12 months	M-M-R II <input type="checkbox"/> Priorix <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Comvax <input type="checkbox"/> Hiberix <input type="checkbox"/> PedvaxHIB <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Meningitec <input type="checkbox"/> NeisVac-C <input type="checkbox"/> Menjugate <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Other (please specify)	/ /	<input type="checkbox"/>
18 months	Varilrix <input type="checkbox"/> Varivax <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Other (please specify)	/ /	<input type="checkbox"/>
4 years	Infanrix <input type="checkbox"/> Infanrix IPV <input type="checkbox"/> Quadracel <input type="checkbox"/> Tripacel <input type="checkbox"/>	/ /	<input type="checkbox"/>
	IPOL <input type="checkbox"/> Oral Polio <input type="checkbox"/>	/ /	<input type="checkbox"/>
	M-M-R II <input type="checkbox"/> Priorix <input type="checkbox"/>	/ /	<input type="checkbox"/>
	Other (please specify)	/ /	<input type="checkbox"/>

Parent Name: _____ Signature: _____ Date: _____



Get Paid On The Dot
ABN 67 096 902 813

Sheridan Meadows
Child Care Centre

Ph: (07) 4036 2777 Fax: (07) 4036 2201

New Customer Form

Direct Debit Request

Customer Reference: SHM GEN 18194

Surname: (Or Business Name) Given Name:

Mobile Ph:

Email:

Debit Arrangement / Payment Details

And/Or the total amount billed for the specified period for this and any other subsequent agreements or amendments.

I authorise and request the debit user detailed below to debit payments from my nominated account, as specified below, at intervals and amounts as directed by Sheridan Meadows Child Care Centre as per the Terms and Conditions of the Sheridan Meadows Child Care Centre agreement and subsequent agreements.

Fees / Charges	Paid by	Transaction	Fee:	Credit	Card Fee:	Rate	SMS Payment	Reminder:	N/A
Administration Fee:	Business		\$0.77	Card Fee:	Amex/Diners	2.2% (min \$0.77)			N/A
			\$0.77			4.4% (min \$0.77)			N/A
						4.4% (min \$0.77)			N/A

Debit from Bank, Building Society or Credit Union Account

Direct Debit is not available on the full range of accounts - if in doubt please refer to your financial institution

Financial Institution: Branch:

BSB Number: - Account Number: (9 Digits MAX)

Account Holder Name(s):

I / We authorise Ezi Debit Australia Pty Ltd User ID 165969 to debit my/our account at the Financial Institution identified above through the Bulk Electronic Clearing System (BECS) in accordance to the Payment Details stated above and as per the Service Agreement provided.

Debit from Credit Card

VISA MasterCard AMEX Diners

Card Number:

Expiry Date: /

Card Holder Name:

By signing this form, I / We authorise Ezi Debit Australia Pty Ltd, acting on behalf of the business to debit payments from my specified credit card above, and I / we acknowledge that Ezi Debit Australia will appear as the business name on my credit card statement.

This Authorisation is to remain in force in accordance with the Terms and Conditions on this page, the provided Service Agreement, and I/we have read and understand the same.

Signature(s) of Nominated Account

Date

/ /

Office Use Only:

T1

Received Date:

Reference No:

Ver 1.0

COMPLETE USING BLACK INK ONLY

DDR Service Agreement

I/We hereby authorize Ezi Debit Australia Pty Ltd (ACN: 096 902 813) **Direct Debit User ID number 165969** (herein referred to as Ezi Debit) to make periodic debits on behalf of the "Business" as indicated on the front of this Direct Debit Request (herein referred to as the Business)

I/We acknowledge that Ezi Debit is acting as a Direct Debit Agent for the Business and that Ezi Debit does not provide any goods or services and has no express or implied liability in regards to the goods and services provided by the Business or the terms and conditions of any agreement with the Business.

I/We acknowledge that the debit amount will be debited from my/our account according to the terms and conditions of the agreement with the Business.

I/We acknowledge that bank account and credit card details have been verified against a recent bank statement to ensure accuracy of the details provided. If uncertain you should contact your financial institution.

I/We acknowledge that it is my/our responsibility to ensure that there is sufficient cleared funds in the nominated account by the due date to enable the direct debit to be honoured on the debit date. Direct debits normally occur overnight; however transactions can take up to three (3) business days depending on your financial institution. 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, I/We agree that Ezi Debit will not be held responsible for any fees and charges that may be charged by your financial institution.

I/We Acknowledge that there may be a delay in processing if:

- 1) There is a public or bank holiday on the day, or any day after the debit date
 - 2) A payment request is received by Ezi Debit on a day that is not a Banking Business Day
 - 3) A Payment request is received after normal Ezi Debit cut off times, being 4pm QLD time Monday to Friday.
- Any payments that fall due on any of the above will be processed on the next business day.

I/We authorise the Business to vary the amount of the payments from time to time as provided for within the Business agreement. I/We authorise Ezi Debit to vary the amount of the payments upon instructions from the Business. I/We do not require Ezi Debit to notify me/us of such variations to the debit amount.

I/We acknowledge that the business is to provide 14 days notice if proposing to vary the terms of the debit arrangements.

I/We acknowledge that variations to the debit arrangement will be directed to the Business.

I/We acknowledge that any request to stop or cancel the debit arrangement will be directed to the Business.

I/We acknowledge that any disputed debit payments will be directed to the Business. If no resolution is forthcoming you are advised to contact your financial institution.

I/We acknowledge that if a debit is returned by my/our financial institution as unpaid, I/We will be responsible for any fees and charges for each unsuccessful debit in addition to any financial institution charges and collection fees, including and not limited to any solicitor fees and collection agent fees appointed by Ezi Debit.

I/We authorise Ezi Debit to attempt to re-process any unsuccessful payments as advised by the Business.

I/We acknowledge that if specified by the Business, a setup, variation, SMS or processing fees may apply as instructed by the Business.

Credit Card Payments

I/We acknowledge that "Ezi Debit Australia" will appear as the business name for all payments from credit card. I/We acknowledge and agree that Ezi Debit will not be held liable for any disputed transactions resulting in the non supply of goods and/or services and that all disputes will be directed to the business as Ezi Debit is acting as a 3rd party payment provider. I/We Acknowledge and agree that in the event that a claim is made, Ezi Debit will not be liable for the refund of any funds.

Ezi Debit will keep your information about your nominated account at the financial institution private and confidential unless this information is required to investigate a claim made in it relating to an alleged incorrect or wrongful debit, or otherwise required by law. Further information relating to Ezi Debit's Privacy Policy can be found at www.ezidebit.com.au

Credit Card Fees are a minimum of the transaction fee or the credit card fee which ever is greater.

I/We authorise:

- 1) The Debit User to verify details of my/our account with my/our financial institution
- 2) The Financial Institution to release information allowing the Debit User to verify my/our account details.