AUTHORIZATION FOR DIRECT PAYMENT

I (we) hereby authorize _Kids Inc./Sioux Falls School District 49-5
to initiate debit entries to my (our) Checking or Savings Account indicated below. To properly affect the cancellation of this agreement, I (we) are required to notify Kids Inc. Office Staff of any changes to our account at least 3 business days prior to a payment. **Child Name: ___________________________**

YOUR NAME—PLEASE PRINT **PHONE #**

SIGNATURE **DATE**

NAME OF FINANCIAL INSTITUTION

_________________________ _______________________________

ROUTING NUMBER **ACCOUNT NUMBER (complete)**

Check "X" appropriate account type below

_______ CHECKING **_______ SAVINGS**

You can scan and email fully completed forms to Abby.Wheeler@k12.sd.us