

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**