

# CLUB CTK

## PARENT FIELD TRIP PERMISSION FORM 2023 - 2024

CHRIST THE KING CATHOLIC SCHOOL  
195-B, Room: 002, Brandon Road, Pleasant Hill, CA 94523  
Club Phone: (925) 685-0995  
Club Email: club@ctkschool.org

To the Principal of Christ the King Catholic School:

**Family Name** (Please Print) : \_\_\_\_\_

I hereby consent to my **child:** \_\_\_\_\_ **Grade** \_\_\_\_\_

**child:** \_\_\_\_\_ **Grade** \_\_\_\_\_

(Please Print) **child:** \_\_\_\_\_ **Grade** \_\_\_\_\_

**child:** \_\_\_\_\_ **Grade** \_\_\_\_\_

Participating in occasional field trips to the Canal Trail or 7-Eleven throughout the school year. I understand these will all be WALKING FIELD TRIPS in which all children may participate. These trip dates will be posted on the monthly CLUB CTK Calendar. I understand that, if necessary, I can pick my child up at the field trip destination.

I agree to direct my child to cooperate and follow the directions given by the supervisory personnel in charge of the field trip.

I, the undersigned parent or legal guardian of the minor named above, authorize representatives of Christ the King School to act as my agent to consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provision of the California Medical Practice Act, on the medical staff of an accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization I given in advance of any specific diagnosis, treatment of hospital care being required, but is given to provide specific consent to any and all such diagnosis, treatment or hospital care that the above mentioned physician in the exercise of his or her best judgement may deem advisable.

I understand that any expenses incurred for medical treatment of my child will be first submitted to my personal medical/dental insurance plans. Unpaid benefits can be submitted to Myers-Stevens as a secondary provider.

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Home Phone**

\_\_\_\_\_  
**Mobile Phone**