27108 Mt. Zion Church Road
Mechanicsville, MD 20659
Office Hours—Monday—Thursday 9a.m. to 3p.m.
Preschool Office—301-884-5455 **Church Office—**301-884-4132 **Fax—**301-884-4010
Email—Preschool-mtzion@md.metrocast.net **or** mtzpreschool@gmail.com
Website—Mtzionpreschool.com **Facebook—**Mt. Zion United Methodist Church Preschool

Registration Packet

Dear Parent/Guardian(s),

Thank you for your interest in joining us at Mt. Zion UMC Preschool. The following forms and fees should be returned to the preschool by Aug. 1st in order to officially enroll your child(ren) into our program:

- ☐ Application for Enrollment
- ☐ Enrollment Contract – 2 pages
- ☐ Photo Release & Allergy Information
- ☐ Authorized Pick-Up Information
- ☐ Emergency Form
- ☐ Health Inventory Form with Immuniztion Record and Lead Testing Certificate

  (a portion of this form must be completed by your pediatrician)
- ☐ The non-refundable registration fee is due at registration.
- ☐ The class activity fee and first month's tuition are due by Aug. 1st to ensure your child(ren)'s placement into our program.

Mt. Zion United Methodist Church

Preschool

Application For Enrollment

Mt. Zion UMC Preschool admits students of any race, religion, or ethnic origin.

Child's Information *Please print*

Date / /

Last Name	First Name	Middle Initial
Nickname	Gender M / F	DOB / /
Main Phone ( ) -		
Address	City	State/Zip

Does your child have any known allergies? Y / N Please list allergens, reaction type and treatment (EpiPen, etc.):

Guardian Information

Last Name	First Name	Employer
Relationship to Child	Main Phone ( ) -	Work Phone ( ) -
Address	City Zip	Email:
Last Name	First Name	Employer
Relationship to Child	Main Phone ( ) -	Work Phone ( ) -
Address	City Zip	Email:

Program Selection Please select one. Monthly tuition is based on nine (9) payments, Aug. - Apr.

Choose One	Class	Activity Fee	Monthly Tuition (9mos.)	Yearly Tuition	Registration
O	2s Mon/Wed 9:10a-11:40a	$140.00	$186.00	$1674.00	Registration is a one-time, non-refundable fee; due at the time of application submission. Single child—$50 Family—$70
O	2s Tues/Thurs 9:10a-11:40a	$140.00	$186.00	$1674.00	
O	3s AM Mon-Thurs 9:15a-11:45a	$160.00	$246.00	$2214.00	
O	3s PM Tues-Thurs 12:30p-3:00p	$150.00	$211.00	$1899.00	
O	4s AM Mon-Thurs 9:20a-12:00p	$160.00	$246.00	$2214.00	
O	4s All Day M-Th 9:20a-2:00p	$180.00	$301.00	$2709.00	

The non-refundable registration fee is due at the time of registration.
The activity fee, 1st month's tuition, and all remaining paperwork are due before Aug. 1st of the applicable school year.

Guardian Signature Date

Guardian Signature Date

Staff use: Last _____ First _____ *Date:* _____

Enrollment Contract

Terms and Conditions

I, _____, hereby consent to the enrollment of my child, _____ into Mt. Zion United Methodist Church Preschool for the _____school year. By signing this contract I agree to and accept the following terms and conditions.

- A **non-refundable registration fee** of $50 ($70 for families) is due at the time of registration.
- The class **activity fee** and **first month's tuition** are due August 1.
- **Nine tuition payments** (Aug —April) will be paid at the beginning of each month, unless the yearly tuition has been paid in full, or other prior arrangements have been made.
- Tuition payments received after the fifth of each month are subject to a **$10 late fee**.
- A fee of **$10 and any bank fees incurred** will be charged in the event of a returned check. After a second returned check, all payments must be made in cash, cashier's check, or money order.
- In the event of a withdrawal from the Preschool, a **thirty day notice** or **one month's tuition** in lieu thereof, will be required.
- If the monthly payment cannot be made on time, the Preschool Director should be notified immediately.
- If a default in payment owed to Mt. Zion UMC Preschool occurs, a conference may be held and the child may be removed from the program. If the account is referred to a collection agency, a fee of up to 25% of the principle amount due will be required.

By signing this contract, I agree to pay tuition based on the payment that I have selected. I agree to comply with the above terms and conditions, the school policies as contained in the Parent's Handbook and the Discipline Policy, as well as directives from the Director's office during the enrollment of the above named child. I acknowledge that I have read the Guide to Regulated Child Care (earlychildhood.marylandpublicschools.org).

The following parties acknowledge that this is the entire agreement and that no modification can be made unless made in writing and signed by all signatories to the original contract.

Guardian's Name (Print)	Signature	Date
Guardian's Name (Print)	Signature	Date
Name of Account Payee -if not Guardian (Print)	Signature	Date

Revised 1/19

*Please retain a copy of this contract for your records, and return the original to the Preschool.

Staff use: Last First *Date:*

Enrollment Contract - cont'd

Program and Tuition Payment Plan Selection

I am enrolling my child into the following program. I agree to pay the registration and activity fee for the chosen class.

I select the following class and tuition payment plan:

Program	Choose a Tuition Payment Plan
☐ Two-year-old, Two-day program	☐ **Full-year** tuition payment of $1674.00 ☐ **Nine (9)** tuition payments - Each payment of $186.00 will be paid by the first of each month August - April ☐ **Ten (10)** tuition payments - Each payment of $167.40 will be paid by the first of each month August - May
☐ Three-year-old, Four-day A.M. program	☐ **Full-year** tuition payment of $2,214.00 ☐ **Nine (9)** tuition payments - Each payment of $246.00 will be paid by the first of each month August - April ☐ **Ten (10)** tuition payments - Each payment of $221.40 will be paid by the first of each month August - May
☐ Three-year-old, Three-day P.M. program	☐ **Full-year** tuition payment of $1899.00 ☐ **Nine (9)** tuition payments - Each payment of $211.00 will be paid by the first of each month August - April ☐ **Ten (10)** tuition payments - Each payment of $189.90 will be paid by the first of each month August - May
☐ Four-year-old, Four-day A.M. program	☐ **Full-year** tuition payment of $2,214.00 ☐ **Nine (9)** tuition payments - Each payment of $246.00 will be paid by the first of each month August - April ☐ **Ten (10)** tuition payments - Each payment of $221.40 will be paid by the first of each month August - May
☐ Four-year-old, Four-day Full-day program	☐ **Full-year** tuition payment of $2,709.00 ☐ **Nine (9)** tuition payments - Each payment of $301.00 will be paid by the first of each month August - April ☐ **Ten (10)** tuition payments - Each payment of $270.90 will be paid by the first of each month August - May

Guardian's Name (Print) Signature Date

Guardian's Name (Print) Signature Date

*Please retain a copy of this contract for your records, and return the original to the Preschool.

Staff use: Last First *Date:*

Mt. Zion United Methodist Church

Preschool

Photo Release Form

Mt. Zion UMC Preschool requires your permission to include pictures of your child participating in preschool activities, which may be displayed or published to promote the Preschool Program.

The pictures will be used in social media, bulletin board displays, fliers, or other publications.

Children's names will ***NOT*** be included in any publication.

Child's Name: _____

☐ **Yes**, I give consent for my child to be photographed and possibly included in bulletin board displays, newspapers, Facebook, other social media, and other publications (names will not be included).

☐ **No, please exclude my child from** _____

_____

Parent/Guardian Signature Date

Allergy Information Form

Please inform us of any allergies that your child may have (including foods, animals, medicines, chemicals, etc.), as well as your child's reaction to the allergen, and any treatment that should be administered.

Child's Name: _____

☐ **Yes - My child has the following allergies (please include the reaction type and treatment):**

_____

_____

_____

☐ **No -** My child has no known allergies at this time.

_____

Parent/Guardian Signature Date

Mt. Zion United Methodist Church

Preschool

Authorized Pick-up Information

The following individuals are authorized to pick up my child from Mt. Zion UMC Preschool
(Please include parent/guardian(s) names also).

A copy of each individual's photo ID is required for our records.

Name	Relationship	Phone Number

If someone listed above is unknown to the teaching staff, that person will be required to show the photo ID matching our records, before your child will be released.

Someone, other than those listed above, may take your child home ***only if we have received prior written permission directly from a parent or guardian.***

Parent/Guardian Signature _____ Date _____

EMERGENCY FORM

INSTRUCTIONS TO PARENTS:
(1) Complete all items on this side of the form. Sign and date where indicated.
(2) If your child has a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have your child's health practitioner review that information.

NOTE. THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

Child's Name ______________________________ Birth Date ______________
Last First

Enrollment Date ______________ Hours & Days of Expected Attendance ______________

Child's Home Address ______________________________
Street/Apt. # City State Zip Code

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		Place of Employment: ______________ W:	C:	H:
		Place of Employment: ______________ W:	C:	H:

Name of Person Authorized to Pick up Child *(daily)* ______________________________
Last First Relationship to Child

Address ______________________________
Street/Apt. # City State Zip Code

Any Changes/Additional Information ______________________________

____

ANNUAL UPDATES ______________ ______________ ______________ ______________
(Initials/Date) *(Initials/Date)* *(Initials/Date)* *(Initials/Date)*

When parents/guardians cannot be reached, list at least one person who may be contacted to pick up the child in an emergency.

1. Name ______________________________ Telephone (H) ______________ (W) ______________
Last First

Address ______________________________
Street/Apt. # City State Zip Code

2. Name ______________________________ Telephone (H) ______________ (W) ______________
Last First

Address ______________________________
Street/Apt. # City State Zip Code

3. Name ______________________________ Telephone (H) ______________ (W) ______________
Last First

Address ______________________________
Street/Apt. # City State Zip Code

Child's Physician or Source of Health Care ______________________________ Telephone ______________

Address ______________________________
Street/Apt. # City State Zip Code

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the child care facility to have your child transported to that hospital.

Signature of Parent/Guardian ______________________________ Date ______________

INSTRUCTIONS TO PARENT/GUARDIAN:

(1) Complete the following items, as appropriate, if your child has a condition(s) which might require emergency medical care.

(2) If necessary, have your child's health practitioner review the information you provide below and sign and date where indicated.

Child's Name: ______________________________ Date of Birth: ______________

Medical Condition(s): ______________________________

____

Medications currently being taken by your child: ______________________________

____

Date of your child's last tetanus shot: ______________________________

Allergies/Reactions: ______________________________

____

EMERGENCY MEDICAL INSTRUCTIONS:

(1) Signs/symptoms to look for: ______________________________

____

(2) If signs/symptoms appear, do this: ______________________________

(3) To prevent incidents: ______________________________

____

- -

OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED: ______________________________

____

____

____

COMMENTS: ______________________________

____

____

____

____

Note to Health Practitioner:

If you have reviewed the above information, please complete the following:

______________________________ Name of Health Practitioner

______________________________ Date

______________________________ Signature of Health Practitioner

(_____)______________________________ Telephone Number

MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

HEALTH INVENTORY

Information and Instructions for Parents/Guardians

REQUIRED INFORMATION

The following information is required prior to a child attending a Maryland State Department of Education licensed, registered or approved child care or nursery school:

- ***A physical examination*** *by a physician or certified nurse practitioner completed no more than twelve months prior to attending child care. A Physical Examination form designated by the Maryland State Department of Education and the Department of Health and Mental Hygiene shall be used to meet this requirement (See COMAR 13A.15.03.02, 13A.16.03.02 and 13A.17.03.02).*
- ***Evidence of immunizations****. A Maryland Immunization Certification form for newly enrolling children may be obtained from the local health department or from school personnel. The immunization certification form (DHMH 896) or a printed or a computer generated immunization record form and the required immunizations must be completed before a child may attend. This form can be found at: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf*
- ***Evidence of Blood-Lead Testing for children living in designated at risk areas****. The blood-lead testing certificate (DHMH 4620) (or another written document signed by a Health Care Practitioner) shall be used to meet this requirement. This form can be found at: http://apps.fcps.org/dept/health/MarylandDHMHBloodLeadTestingCertificateDHMH4620.pdf*

EXEMPTIONS

Exemptions from a physical examination, immunizations and Blood-Lead testing are permitted if the family has an objection based on their religious beliefs and practices. The Blood-Lead certificate must be signed by a Health Care Practitioner stating a questionnaire was done.

Children may also be exempted from immunization requirements if a physician, nurse practitioner or health department official certifies that there is a medical reason for the child not to receive a vaccine.

The health information on this form will be available only to those health and child care provider or child care personnel who have a legitimate care responsibility for your child.

INSTRUCTIONS

Please complete Part I of this Physical Examination form. Part II must be completed by a physician or nurse practitioner, or a copy of your child's physical examination must be attached to this form.

If your child requires medication to be administered during child care hours, you must have the physician complete a Medication Authorization Form (OCC 1216) for each medication. The Medication Authorization Form can be obtained at

http://www.marylandpublicschools.org/NR/rdonlyres/B0050A99-6B3C-4396-A996-CC9405971A42/30754/1216_MedAuth_r120511.pdf

If you do not have access to a physician or nurse practitioner or if your child requires an individualized health care plan, contact your local Health Department.

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____ **Birth date:** _____ **Sex** M☐F☐
Last First Middle Mo / Day / Yr

Address: _____
Number Street Apt# City State Zip

Parent/Guardian Name(s)	Relationship	Phone Number(s)		
		W:	C:	H:
		W:	C:	H:

Where do you usually take your child for routine medical care? **Name:**

Address: **Phone Number:**

When was the last time your child had a physical exam? **Month:** **Year:**

Where do you usually take your child for dental care? **Name:**

Address: **Phone Number:**

ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.

	Yes	No	Comments (required for any Yes answer)
Allergies (Food, Insects, Drugs, Latex, etc.)	☐	☐	
Allergies (Seasonal)	☐	☐	
Asthma or Breathing	☐	☐	
Behavioral or Emotional	☐	☐	
Birth Defect(s)	☐	☐	
Bladder	☐	☐	
Bleeding	☐	☐	
Bowels	☐	☐	
Cerebral Palsy	☐	☐	
Coughing	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Ears or Deafness	☐	☐	
Eyes or Vision	☐	☐	
Head Injury	☐	☐	
Heart	☐	☐	
Hospitalization (When, Where)	☐	☐	
Lead Poisoning/Exposure	☐	☐	
Life Threatening Allergic Reactions	☐	☐	
Limits on Physical Activity	☐	☐	
Meningitis	☐	☐	
Prematurity	☐	☐	
Seizures	☐	☐	
Sickle Cell Disease	☐	☐	
Speech/Language	☐	☐	
Surgery	☐	☐	
Other	☐	☐	

Does your child take medication (prescription or non-prescription) at any time?

☐ No ☐ Yes, name(s) of medication(s):

Does your child receive any special treatments? (nebulizer, epi-pen, etc.)

☐ No ☐ Yes, type of treatment:

Does your child require any special procedures? (catheterization, G-Tube, etc.)

☐ No ☐ Yes, what procedure(s):

I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.

I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Parent/Guardian Date

PART II - CHILD HEALTH ASSESSMENT

To be completed *ONLY* by Physician/Nurse Practitioner

Child's Name: Last / First / Middle	Birth Date: Month / Day / Year	Sex M ☐ F ☐

1. Does the child named above have a diagnosed medical condition?

☐ No ☐ Yes, describe:

2. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card.

☐ No ☐ Yes, describe:

3. PE Findings

Health Area	WNL	ABNL	Not Evaluated	Health Area	WNL	ABNL	Not Evaluated
Attention Deficit/Hyperactivity	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐	☐
Behavior/Adjustment	☐	☐	☐	Mobility	☐	☐	☐
Bowel/Bladder	☐	☐	☐	Musculoskeletal/orthopedic	☐	☐	☐
Cardiac/murmur	☐	☐	☐	Neurological	☐	☐	☐
Dental	☐	☐	☐	Nutrition	☐	☐	☐
Development	☐	☐	☐	Physical Illness/Impairment	☐	☐	☐
Endocrine	☐	☐	☐	Psychosocial	☐	☐	☐
ENT	☐	☐	☐	Respiratory	☐	☐	☐
GI	☐	☐	☐	Skin	☐	☐	☐
GU	☐	☐	☐	Speech/Language	☐	☐	☐
Hearing	☐	☐	☐	Vision	☐	☐	☐
Immunodeficiency	☐	☐	☐	Other:	☐	☐	

REMARKS: (Please explain any abnormal findings.)

4. **RECORD OF IMMUNIZATIONS** – DHMH 896/or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider or a computer generated immunization record must be provided. (This form may be obtained from: http://ideha.dhmh.maryland.gov/IMMUN/pdf/896_form.pdf)

RELIGIOUS OBJECTION:

I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Parent/Guardian Signature: Date:

5. Is the child on medication?

☐ No ☐ Yes, indicate medication and diagnosis:

(OCC 1216 Medication Authorization Form must be completed to administer medication in child care).

6. Should there be any restriction of physical activity in child care?

☐ No ☐ Yes, specify nature and duration of restriction:

7. Test/Measurement	Results	Date Taken
Tuberculin Test		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test Indicated: ☐ Yes ☐ No		

(Child's Name) **has had a complete physical examination and any concerns have been noted above.**

Additional Comments:

Physician/Nurse Practitioner (Type or Print):	Phone Number:	Physician/Nurse Practitioner Signature:	Date:

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BLOOD LEAD TESTING CERTIFICATE

Instructions: Use this form when enrolling a child in child care, pre-kindergarten, kindergarten or first grade. **BOX A** is to be completed by the parent or guardian. **BOX B**, also completed by parent/guardian, is for a child born before January 1, 2015 who does not need a lead test (children must meet all conditions in Box B). **BOX C** should be completed by the health care provider for any child born on or after January 1, 2015, and any child born before January 1, 2015 who does not meet all the conditions in Box B. **BOX D** is for children who are not tested due to religious objection (must be completed by health care provider).

BOX A-Parent/Guardian Completes for Child Enrolling in Child Care, Pre-Kindergarten, Kindergarten, or First Grade

CHILD'S NAME _____ / _____ / _____
LAST FIRST MIDDLE

CHILD'S ADDRESS _____ / _____ / _____ / _____
STREET ADDRESS (with Apartment Number) CITY STATE ZIP

SEX: ❑Male ❑Female BIRTHDATE ____/____/____ PHONE _____

PARENT OR GUARDIAN _____ / _____ / _____
LAST FIRST MIDDLE

BOX B – For a Child Who Does Not Need a Lead Test (Complete and sign if child is NOT enrolled in Medicaid AND the answer to EVERY question below is NO):

Was this child born on or after January 1, 2015? ❑ YES ❑ NO
Has this child ever lived in one of the areas listed on the back of this form? ❑ YES ❑ NO
Does this child have any known risks for lead exposure (see questions on reverse of form, and talk with your child's health care provider if you are unsure)? ❑ YES ❑ NO

If all answers are NO, sign below and return this form to the child care provider or school.

Parent or Guardian Name (Print): _____ **Signature**: _____ **Date**: _____

If the answer to ANY of these questions is YES, OR if the child is enrolled in Medicaid, do not sign Box B. Instead, have health care provider complete Box C or Box D.

BOX C – Documentation and Certification of Lead Test Results by Health Care Provider

Test Date	Type (V=venous, C=capillary)	Result (mcg/dL)	Comments

Comments:

Person completing form: ❑Health Care Provider/Designee OR ❑School Health Professional/Designee

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

BOX D – Bona Fide Religious Beliefs

I am the parent/guardian of the child identified in Box A, above. Because of my bona fide religious beliefs and practices, I object to any blood lead testing of my child.

Parent or Guardian Name (Print): _____ Signature: _____ Date: _____

****

This part of BOX D must be completed by child's health care provider: Lead risk poisoning risk assessment questionnaire done: ❑ YES ❑ NO

Provider Name: _____ Signature: _____

Date: _____ Phone: _____

Office Address: _____

HOW TO USE THIS FORM

The documented tests should be the blood lead tests at 12 months and 24 months of age. Two test dates and results are required if the first test was done prior to 24 months of age. If the first test is done after 24 months of age, one test date with result is required. The child's primary health care provider may record the test dates and results directly on this form and certify them by signing or stamping the signature section. A school health professional or designee may transcribe onto this form and certify test dates from any other record that has the authentication of a medical provider, health department, or school. All forms are kept on file with the child's school health record.

At Risk Areas by ZIP Code from the 2004 Targeting Plan (for children born BEFORE January 1, 2015)

Allegany
ALL

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210

Baltimore Co. (Continued)
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Cecil
21913

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769

Frederick (Continued)
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George's
20703
20710
20712
20722
20731

Prince George's (Continued)
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne's
21607
21617
21620
21623
21628

Queen Anne's (Continued)
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary's
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

Lead Risk Assessment Questionnaire Screening Questions:

1. Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
2. Ever lived outside the United States or recently arrived from a foreign country?
3. Sibling, housemate/playmate being followed or treated for lead poisoning?
4. If born before 1/1/2015, lives in a 2004 "at risk" zip code?
5. Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items (pica)?
6. Contact with an adult whose job or hobby involves exposure to lead?
7. Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
8. Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, pottery or pewter.