NAME:_____ **DATE:**_____

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My body

D F
L D A V
J E C A P X
W K Y F Y B A E
Q H V E A O A Y R J
N G E F J C P O K H M R
T P F A E A U E H T L T H T
O C W H D C D T O L X L O R K I
E A I B F W N R Q K Z G Z A B G Z Y
N E V Y N M H D B S Q P S F I N G E R L
F A D I J S F Z J N R S D E K N R A E J
Q M P N B M E D O U I U J R M E N E
E S L D O N E I S H O U L D E R
M L K N E E T A Y U M S P L
O T O I O I U H O N A E
P S D R G K N K M G
E W F D E M O L
L P N I U N
Z A T N
H S

HEAD
SHOULDER
KNEE
TOE
HAND
FINGER
ARM
MOUTH
EYE
EAR
NOSE
HAIR
FOOT
FEET
LEG