

Name: \_\_\_\_\_

Score: \_\_\_\_\_

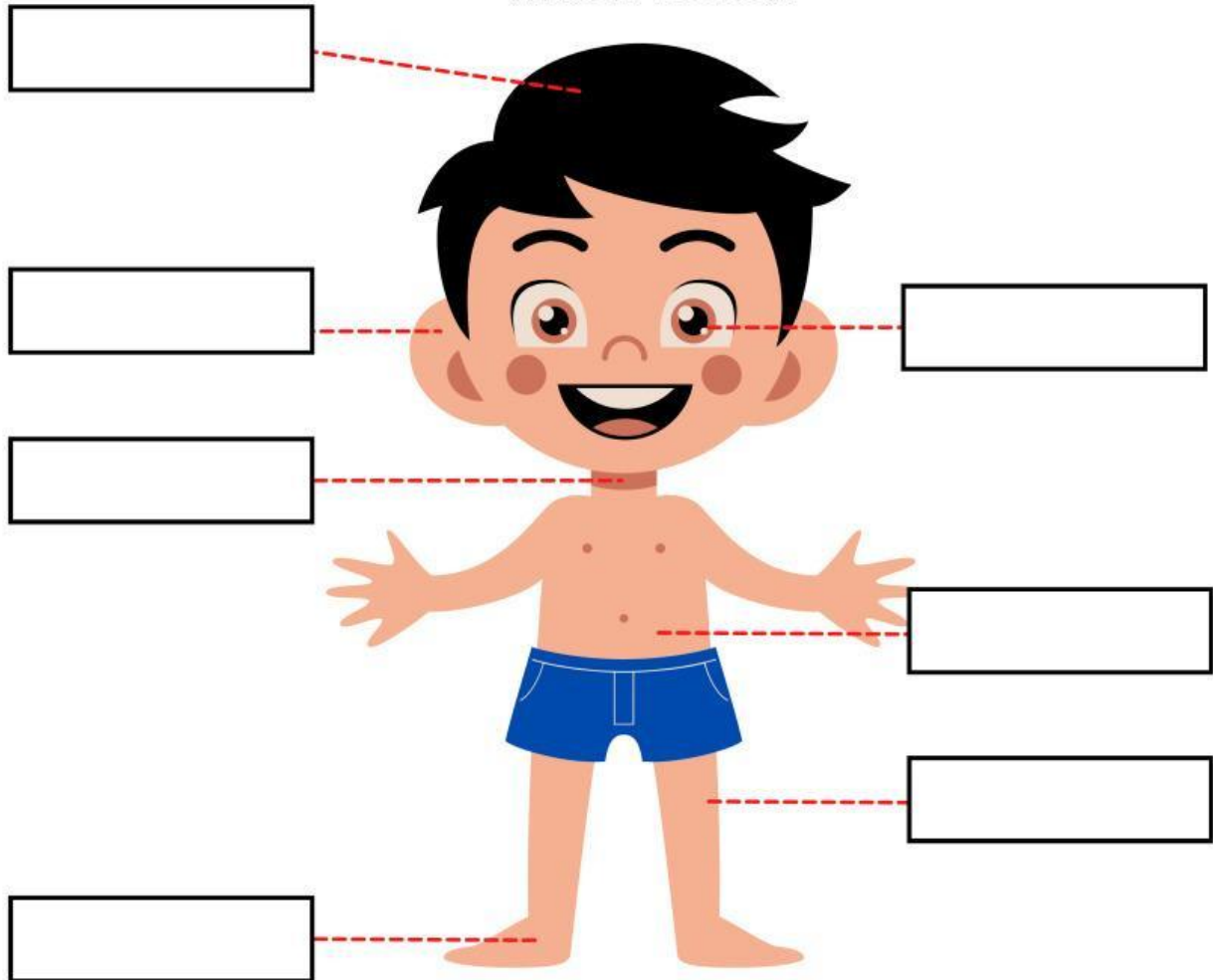
Class: \_\_\_\_\_

Date: \_\_\_\_\_

# My Body

Directions: Choose the correct answer below.

Write in the box.



foot

neck

ear

hair

eye

stomach

knee