

Name: _____

Date: _____

MY BODY

D L E Y E I L Z A Q

A W K C S W E G I Y

A C F M X Q G J O Z

H L I O V E A R M A

F O O T X H A N D S

R A Y F E E T V E C

U R C H N L N O S E

X M Y E H A I R S Z

I T D A A N U M R X

V F F D X N E C K K

NOSE

HAIR

HAND

HEAD

NECK

FEET

FOOT

EYE

EAR

ARM

LEG