

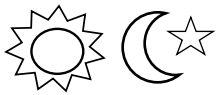
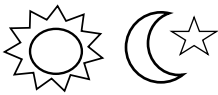
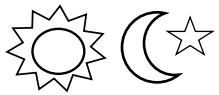
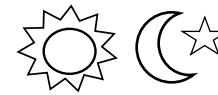
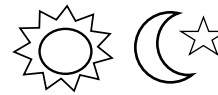
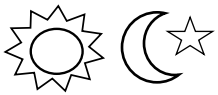
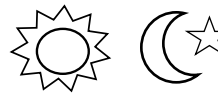
Name: _____ Class: _____

Teacher: _____ Date: _____



Brush your Teeth

Please put a check mark in the square for each time you brush and floss your teeth.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						



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