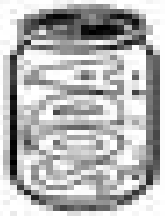
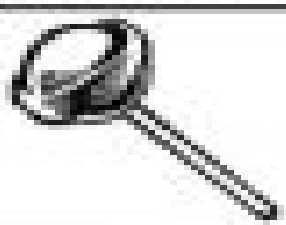
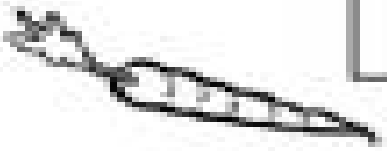
Name: _____ Date: _____

Write an X on the box for the things that can harm your teeth.

| | |
|---|---|
| 1.  ☐ | 2.  ☐ |
| 3.  ☐ | 4.  ☐ |
| 5.  ☐ | 6.  ☐ |
| 7.  ☐ | 8.  ☐ |