

Name: _____

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|--|---|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Trachea | <input type="checkbox"/> Alveoli | <input type="checkbox"/> Nasal Cavity | <input type="checkbox"/> Larynx |
| <input type="checkbox"/> Bronchiole | <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Pharynx | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Left Bronchus | <input type="checkbox"/> Right Bronchus | <input type="checkbox"/> Mouth Cavity | |

