


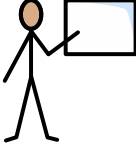
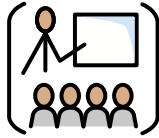

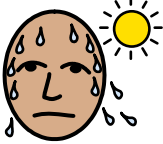




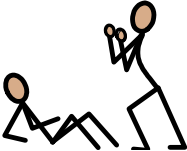
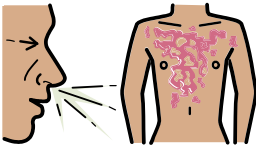



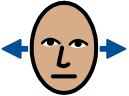




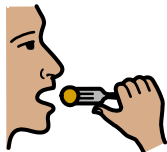


10  
9  
8  
7  
6  
5  
4  
3  
2  
1  
0



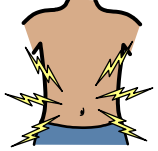
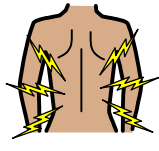





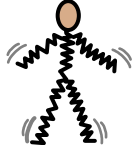


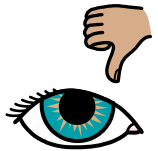
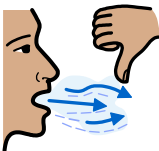
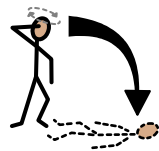
 Your name?	 Phone number?	 Parents	 Teacher	 class
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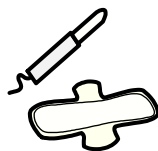



 Please wait here	 Please lie down	 Please sit down	 This won't hurt	 Check for injuries
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 diabetes	 hot	 cold	 tired	 afraid
 Do you take medicine?	 Did someone hurt you?	 allergies	 pregnant	 drinking alcohol


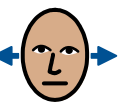
 yes	 No
--	---

 bathroom	 drink	 eat	 painkiller	 contact relative
---	---	--	---	---

 headache	 sore throat	 stomach ache	 back ache	 chest pain
 dizzy	 vomit	 diarrhea	 fever	 seizure
 tooth ache	 difficulty hearing	 difficulty seeing	 difficulty breathing	 unconscious

 new clothes	 sanitary napkins	 spray	 blood pressure	 bandage
---	---	---	--	---

 dentist	 police	 ambulance	 hospital	 home
--	--	--	---	---

 yes	 No
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