

Name \_\_\_\_\_

Date \_\_\_\_\_

# Summer or Rainy?

Put a ✓ in the right column for each picture.

|                                                                                              | Summer                   | Rainy                    |
|----------------------------------------------------------------------------------------------|--------------------------|--------------------------|
|  watermelon | <input type="checkbox"/> | <input type="checkbox"/> |
|  ice cream  | <input type="checkbox"/> | <input type="checkbox"/> |
|  rain      | <input type="checkbox"/> | <input type="checkbox"/> |
|  fan      | <input type="checkbox"/> | <input type="checkbox"/> |
|  cloud    | <input type="checkbox"/> | <input type="checkbox"/> |
|  sun      | <input type="checkbox"/> | <input type="checkbox"/> |
|  umbrella | <input type="checkbox"/> | <input type="checkbox"/> |
|  raincoat | <input type="checkbox"/> | <input type="checkbox"/> |