

Recording Sheet

Name Date _____

First Hour Data:

<input type="checkbox"/>	Paper Clips <input type="checkbox"/>	Macaroni <input type="checkbox"/>	Rubber Bands <input type="checkbox"/>	Toothpicks
<input type="checkbox"/> Scissors				
<input type="checkbox"/> Spoons				
<input type="checkbox"/> Tweezers				
<input type="checkbox"/> Binder Clips				

Second Hour Data:

<input type="checkbox"/>	Paper Clips <input type="checkbox"/>	Macaroni <input type="checkbox"/>	Rubber Bands <input type="checkbox"/>	Toothpicks
<input type="checkbox"/> Scissors				
<input type="checkbox"/> Spoons				
<input type="checkbox"/> Tweezers				
<input type="checkbox"/> Binder Clips				