



**Polio Survivor Treatment Warnings
For Medical Personnel And Caregivers
I am a Polio Survivor with Post-Polio Sequelae.**

I can:

**Be EASILY SEDATED, and may be difficult to wake
Have Difficulty BREATHING and SWALLOWING with Anesthesia
Be HYPERSENSITIVE to PAIN and COLD.**

Need a HEATED BLANKET and Need to have Increased Pain Medication post-op.

Name: _____ **Date of Birth:** _____

I have these Symptoms of Post-Polio Syndrome (PPS) - checked:

- | | |
|--|--|
| <input type="checkbox"/> Overwhelming Fatigue | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Muscle and Joint Pain | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Sensitivity to Anesthesia |

**** Anesthesia Warning ****

Preventing Complications in Polio Survivors Undergoing Surgery

www.polionetwork.org/anesthesia-card



Breathing Outcomes for Post-Poliomyelitis Syndrome

Breathing and Ventilation Information

www.breathenvs.com



Encyclopedia of Polio and PPS

Information for all Subjects related to PPS

www.polionetwork.org/encyclopedia



Information on Multiple Subjects Related to PPS

Post-Polio Care for Families and Health Care Providers

www.polionetwork.org/living-with-post-polio-syndrome



Post-Polio Health International

www.post-polio.org



Please take this information into account, when you are creating my treatment plan.

I have added additional information, relating to my medical history, on the back side of this page. (Allergies, Current Medications, Tests Etc.)

Signature: _____ **Date:** _____