



October 5, 2026

The Honorable Bryan Bedford
Administrator
Federal Aviation Administration
800 Independence Avenue, SW
Washington, DC 20591
Submitted via regulations.gov

Re: Improving Emergency Medical Kit Efficacy and Flexibility in Commercial Airline Operations (Docket No. FAA-2026-9178)

Dear Mr. Bedford:

On behalf of the Asthma and Allergy Foundation of America, I write to express serious concerns regarding the FAA's proposed rulemaking on "Improving Emergency Medical Kit Efficacy and Flexibility in Commercial Airline Operations." The proposal reflects a missed opportunity to set a clear, evidence-based floor for the safety of airline passengers.

AAFA is the leading patient organization for people with asthma and allergies and the oldest asthma and allergy patient group in the world. AAFA focuses on saving and improving lives for the over 100 million people in the U.S. with asthma and allergic diseases. We are dedicated to improving the quality of life for people with allergic diseases and asthma through education, support, advocacy and research.

AAFA strongly urges FAA to:

1. Explicitly require the inclusion of an FDA-approved epinephrine delivery system designed for self-administration on all airplanes.
2. Specify that epinephrine be included in rapidly accessible first aid kits, rather than sealed emergency medical kits, to permit lay administration and prevent dangerous delays in response.

Our concerns are detailed below.



Background: Food Allergies and Epinephrine

Food allergies represent a significant health burden in the U.S., impacting 5.3% of children¹ and 6.7% of adults.² Food allergies can trigger a severe reaction called anaphylaxis that in rare cases can lead to death. Unfortunately, the prevalence and impact of food allergies in the U.S. are increasing; for example, the rate of emergency room visits for food-related anaphylaxis increased by 124% from 2005 through 2014.³

Epinephrine is the only treatment for anaphylaxis, and must be administered promptly.⁴ When epinephrine is delayed, the individual's response may be delayed or impaired.⁵ There are multiple epinephrine auto-injectors on the market, including generics, and auto injectors with appropriate dosing for children and infants. There is also an FDA-approved nasal spray device. All of these options can be administered by lay people with minimal training or instruction.

Most people with diagnosed food allergies are prescribed epinephrine devices and instructed to always have one at hand. AAFA strongly supports access and coverage for this purpose. However, in an in-flight emergency, an individual may not be able to find their device or indicate to airplane personnel where it is. In addition, children and adults with new food allergies may experience their first reaction while traveling, and not have a prior prescription. Because food is commonly served on planes and reactions can and do occur in the air, epinephrine must be available to respond to anaphylaxis until a person can receive on-the-ground care.

Current FAA Policy and the FAA Reauthorization

¹ Giri, Abhigya;Ng, Amanda E.;Bottoms-McClain, Lauren. Diagnosed Allergic Conditions in Children Ages 0-17: United States, 2024 (2026). National Center for Health Statistics (U.S.). Available at <https://stacks.cdc.gov/view/cdc/174635>

² Ng, Amanda E.;Giri, Abhigya;Bottoms-McClain, Lauren. Diagnosed Allergic Conditions in Adults: United States, 2024 (2026) National Center for Health Statistics (U.S.). Available at <https://stacks.cdc.gov/view/cdc/174634>.

³ Motosue et al., "Increasing Emergency Department Visits for Anaphylaxis, 2005-2014." J Allergy Clin Immunol Pract. 2017 Jan - Feb;5(1):171-175.

⁴ Golden DBK, Wang J, Wasserman S, Akin C, Campbell RL, Ellis AK, et al. Anaphylaxis: A 2023 practice parameter update. Ann Allergy Asthma Immunol. 2024;132(2):124-76.

⁵ *Id.*



Under current policy, airlines are required to include epinephrine in their Emergency Medical Kits (EMKs), but it is only required to be available in a vial. The appropriate adult or child dosage must be identified, withdrawn with a syringe, and administered by injection. This is woefully inadequate and out of date. First, medical personnel are not always available on a flight. Even when they are, medical personnel who have voluntarily provided medical care on planes have reported that it can be extremely difficult to use a syringe and vial given the motion of the aircraft.

Because of these problems, AAFA was highly supportive of the provisions in the 2024 FAA Reauthorization Act that related to onboard emergency kits. In Section 367, the law reflects the sense of Congress that “a regularly scheduled panel of experts should reexamine and provide an updated list of mandated contents of onboard emergency medical kits that is thorough and practical, keeping passenger safety and well-being paramount.” In Section 368, Congress directed the FAA Administrator to promulgate a rule on first aid and emergency medical kit equipment and training required for flight crewmembers. The Administrator is directed to consider “whether the contents of the emergency medical kits include, at a minimum, appropriate medications and equipment that can practicably be administered to address” a set of specific emergency conditions, including “anaphylaxis.” The law also directs the FAA Administrator to consider “what contents of the emergency medical kits should be readily available, to the extent practicable, for use by flight crews without prior approval by a medical professional.”

Epinephrine in the Proposed Rule

Because epinephrine is the *only* treatment for anaphylaxis, and because auto-injectors and nasal sprays are far more suitable to be “practically administered” than the vial-and-syringe option, this statutory language should have resulted in the mandatory inclusion of modern epinephrine devices on airplanes.

Unfortunately, FAA has instead proposed an approach that takes us backward, not forward.

1. The proposed rule does not specifically require the inclusion of epinephrine.

Instead of specifying the content of on-board kits – as the sense of Congress in Section 367 recommends – the proposed rule shifts to “performance-based”



requirements that don't specify the contents of the kits at all. This approach contradicts the Congressionally-mandated set of recommendations

With regard to anaphylaxis, the preamble states:

FAA recommends sufficient resources for anaphylaxis (sudden/acute severe allergic reaction), which may include the following signs and symptoms: hives; swelling of the mouth, throat, or tongue; difficulty breathing, rapid or weak pulse, dizziness; stomach pain; nausea or vomiting; or loss of consciousness. Treatment options could include medication such as epinephrine. (emphasis added)

As noted above, epinephrine is the **only** treatment for anaphylaxis. Telling airlines that treatment options for anaphylaxis "could include" epinephrine suggests that other options exist, when they do not. Airlines could misguidedly determine that other allergy medications, such as Benadryl, might be appropriate substitutes.

2. The proposed rule does not reflect modern or practicable options for epinephrine administration.

Section 368 directs the Administrator to consider when medications and supplies can "practicably be administered" in case of emergency. Vials and syringes are not practicable on an airplane, even in the hands of medical professionals, and especially when no medical professionals are present. There are numerous branded and generic epinephrine devices on the market, all of which can be used or administered by laypeople with simple training.

In addition to disregarding Congress's directive on practicability, FAA is contradicting its own stated goal of allowing airlines to "keep[]up with the most modern medical scientific developments." FDA approved the first epinephrine auto injector in 1987. Keeping up with modern medical developments, in this context, would mean updating from a vial-and-syringe requirement to requiring the inclusion of auto injectors or nasal spray devices.

3. The Proposed Rule does not make epinephrine easily accessible.



As discussed above, epinephrine must be administered promptly, at the first signs of anaphylaxis. Because of this urgency, and because auto injectors and nasal spray can be easily administered by a layperson, these devices should be in the First Aid Kit (FAK) that flight crew can easily access and open, rather than the sealed Emergency Medical Kit (EMK).

4. The FAA's argument regarding the exemption process is unpersuasive.

To support its "performance-based" approach, FAA argues that requiring the inclusion of specific medications in the airline kits leaves airlines vulnerable to grounding and delays when specific medications are unavailable. This argument is unconvincing. First, airlines have reported "drug shortages" when no such shortage was identified by FDA, suggesting that the problem is not external to the airlines but rather a failure on their part to procure needed items in a timely manner. Secondly, if the process for exemptions is burdensome, it should be revised, rather than entirely eliminating all minimum standards for the specific components of first aid and emergency kits.

For anaphylaxis, a requirement will inherently include flexibility because there are multiple devices on the market. Requiring the inclusion of appropriate child, and adult doses of *any* epinephrine auto injector or nasal device would give airlines many options to choose from. What's more, language such as "any FDA-approved, self-administrable device for the treatment of anaphylaxis" would keep the requirement "evergreen" if newer modalities are approved.

Recommendation

AAFA strongly urges FAA to require the inclusion of auto injectors or nasal spray, or any other FDA-approved treatment for anaphylaxis, in airlines' first aid kits, in both child and adult doses. We also strongly encourage FAA to consider reversing the overall "performance-based" approach, which creates too much uncertainty and risks the safety of passengers with a broad range of health conditions.



Conclusion

We appreciate your consideration of these comments. AAFA would welcome the opportunity to work with FAA to ensure that airlines are ready to address allergic emergencies for the millions of American flyers with food allergies.

If you would like more information, please contact AAFA's Vice President of Policy and Advocacy, Jenna Riemenschneider, at jennar@aafa.org.

Sincerely,

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